EXECUTIVE SUMMARY

INTRODUCTION

As a result of the Legislature's 2001–02 sunset review of the Medical Board of California (MBC), Senate Bill 1950 (Figueroa) added section 2220.1 to the Business and Professions Code.[1] Section 2220.1 provides for the appointment of an independent Medical Board Enforcement Program Monitor for a two-year period, and charges the Monitor with evaluating "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." The statute tasks the Monitor with several specific analyses, including a required evaluation of the Board's Diversion Program for substance-abusing physicians, and requires the Monitor to publish two reports during the two-year appointment period.

Following a year of research, data gathering and analysis, and extensive interviews, the Monitor released the *Initial Report of the Medical Board Enforcement Program Monitor* on November 1, 2004. The report made hundreds of findings and 65 specific recommendations for reform; some of them required legislation, while others could be implemented administratively by MBC. The Medical Board and the Health Quality Enforcement (HQE) Section of the Attorney General's Office quickly embraced nearly all of the Monitor's recommendations, and immediately began to implement those that did not require legislation or additional resources. Commencing in April 2005, many of the Monitor's most important recommendations were amended into Senate Bill 231 (Figueroa), which was signed by Governor Arnold Schwarzenegger on October 7, 2005.

This *Final Report of the Medical Board Enforcement Program Monitor* describes the details of this fundamental reform legislation and its impacts on the various components of the Medical Board's enforcement program. Additionally, it includes updated enforcement program data for fiscal year 2004–05 and documents MBC/HQE implementation of other Monitor recommendations that did not require legislation. The efforts of MBC, HQE, and the Legislature to implement each of the Monitor's 65 recommendations are documented in the matrix in Chapter XVII. Lastly, the *Final Report* includes final recommendations for future consideration by the Medical Board, the Attorney General's Office, the Legislature, and the Schwarzenegger administration.

[1] Unless otherwise noted, all further statutory references in this Executive Summary are to the California Business and Professions Code.

OVERVIEW OF MBC AND ITS ENFORCEMENT PROGRAM

Created in the Medical Practice Act, the Medical Board of California is a semi-autonomous occupational licensing agency within the state Department of Consumer Affairs (DCA). MBC consists of 21 members: twelve California-licensed physicians and nine non-physician "public members," all serving four-year terms. Uniquely, MBC is comprised of two autonomous divisions — the Division of Licensing (DOL) and the Division of Medical Quality (DMQ). DOL, which consists of four physicians and three public members, focuses on the licensure of physicians and the regulation of several non-physician health care professions. DMQ, which consists of fourteen members (eight physicians and six public members), is the Board's enforcement arm. DMQ is responsible for reviewing the quality of medical practice carried out by California physicians; conducting disciplinary proceedings in cases of unprofessional conduct; and generally enforcing the disciplinary and criminal provisions of the Medical Practice Act, other relevant statutes and regulations, and applicable professional standards. The Legislature has declared that, in exercising its disciplinary authority, "[p]rotection of the public shall be the highest priority for the Division of Medical Quality . . . .Where [physician] rehabilitation and protection are inconsistent, protection shall be paramount."

MBC's enforcement program is large, complex, expensive, and fragmented across three state agencies. DMQ oversees a large enforcement staff that receives, screens, and investigates complaints and reports of physician misconduct and negligence. These staff are based at headquarters in Sacramento and at eleven district offices throughout California. Once a Medical Board investigator (assisted by physician employees called "medical consultants" and often external expert physician reviewers) has determined that sufficient evidence exists to take disciplinary action, the matter is transmitted to a separate agency — the Health Quality Enforcement Section of the Attorney General's Office; HQE has six offices throughout the state. A deputy attorney general (DAG) from HQE then files an "accusation," a written statement of formal charges, which triggers a panoply of due process rights for the subject physician. Absent settlement, the charges then become the subject of an evidentiary hearing presided over by an administrative law judge (ALJ) from another separate agency — the Medical Quality Hearing Panel of the Office of Administrative Hearings (OAH) — at which each side presents its case. After the case is "submitted," the ALJ drafts a proposed decision, including findings of fact, conclusions of law, and recommended discipline. That proposed decision is referred back to DMQ, where it is reviewed by one of two "panels" of DMQ, each consisting of seven members (four physicians and three public members). The assigned DMQ panel makes MBC's final disciplinary decision, which is then subject to potentially three levels of review by the courts. Contested MBC disciplinary matters often consume five to eight years, during which time most respondent physicians are free to continue practicing medicine.

The Business and Professions Code sets forth grounds for MBC disciplinary action, including gross negligence (an extreme departure from applicable professional standards); repeated negligent acts; incompetence; the commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician; and the violation of any provision of the Medical Practice Act. In MBC disciplinary matters, the burden of proof is on the Board, and MBC must prove its case by "clear and convincing evidence to a reasonable certainty." The Code also sets forth an array of sanctions that DMQ may impose on a licensee for a disciplinable violation, including license revocation, suspension, probation on specified terms and conditions, public reprimand, citations, fines, and civil penalties.

In 2004–05, MBC regulated over 120,000 physicians, of which 93,000 reside and practice medicine in California. The Medical Board receives no funding or support from the state's general fund. MBC is funded entirely by physician licensing, renewal, and application fees; as such, it is characterized as a "special-fund agency." MBC's fiscal year 2004–05 budget was $41 million, of which $30 million — or 75% — was spent on enforcement.

SUMMARY OF THE *INITIAL REPORT*

On November 1, 2004, the Monitor team released its initial findings and recommendations in the *Initial Report of the Medical Board Enforcement Program Monitor*.[2] These findings highlight significant limitations on the Board's ability to protect the public through its enforcement and diversion programs. Some of them are within the Medical Board's control; others are beyond its control. The Monitor's major findings and recommendations can be summarized as follows:

1. The structure of the Board's enforcement program is inefficient and outdated. The current structure of MBC's enforcement program and process used to handle serious complaints against physicians — which places Medical Board investigators and HQE's specialized prosecutors in separate agencies — is fragmented, inefficient, and outdated. Currently, a Medical Board investigator with little or no legal guidance works up a case and then "hands it off" to a DAG who has had no involvement in the planning or direction of the investigation and then has no investigative assistance thereafter. Most other similar law enforcement agencies use a "vertical prosecution" model in which (1) investigators and prosecutors work for the same entity; (2) an investigator/prosecutor team is assigned to each case as soon as it warrants formal investigation; and (3) that team handles the case as a team through its ultimate conclusion. In the *Initial Report*, the Monitor proposed the transfer of the Medical Board's investigators from the jurisdiction of the

[2] Fellmeth and Papageorge, *Initial Report of the Medical Board Enforcement Program Monitor* (Nov. 1, 2004) (hereinafter "*Initial Report*"). The 294-page report is available on the Medical Board's Web site at www.medbd.ca.gov and on the Web site of the University of San Diego School of Law's Center for Public Interest Law at www.cpil.org.

politically appointed Board to HQE, and recommended full adoption of the vertical prosecution model for improved enforcement efficiency and effectiveness.

The Monitor noted other structural infirmities in MBC's enforcement program. Specifically, existing venue statutes that govern the location of the administrative hearing and the court challenge to any resulting MBC disciplinary action are unnecessarily expensive to the Board and its licensees, and are inconvenient and inefficient for those who must participate in Medical Board disciplinary proceedings — including HQE prosecutors and OAH ALJs. The Monitor recommended amendments to the statutory provisions governing the venue of MBC administrative hearings and judicial challenges to Medical Board disciplinary decisions.

2. The Medical Board has woefully inadequate resources for its important enforcement function. For over a decade, the Medical Board has been starved for budgetary resources: Physicians' license fees have not been increased since January 1994, notwithstanding a 28% increase in the California Consumer Price Index during those eleven years. In addition, the Board has been starved for human resources: Since 2001, MBC has lost 29 enforcement program positions (a 16.2% reduction) and the Attorney General's Office has lost six HQE DAGs (a 15% reduction) due to the state's 2001–04 hiring freeze — contributing greatly to chronic case processing delays. The Monitor called for an increase in physician licensing fees from $610 biennially to at least $800 biennially. These added resources would enable the Board to reinstate investigator/prosecutor positions lost as a result of the hiring freeze, implement vertical prosecution, reform and sufficiently staff its Diversion Program for substance-abusing licensees, reinstate critical programs it was forced to abandon during the eleven-year financial drought, and maintain an adequate reserve fund as required by state law.

3. MBC case processing times are unacceptably high. The Medical Board's enforcement process simply takes too long to protect the public. Although section 2319 requires the Board to set a goal of completing an investigation within 180 days from receipt of the complaint (one year for complex cases), during 2003–04 an average of 340 days elapsed from MBC's receipt of a serious quality of care complaint to the conclusion of the investigation. One reason for this delay is that many physicians refuse to honor lawful MBC requests for patient medical records, and neither MBC investigators nor HQE prosecutors aggressively enforced existing laws governing medical records procurement. Similar delays plague other steps in the long enforcement process, including initial complaint processing, securing physician interviews during an investigation, and the procurement of an expert opinion necessary to prove a violation. The Monitor recommended that MBC and HQE develop and consistently apply new policies to enforce existing medical records procurement laws and to end other frequent delays in obtaining physician interviews and expert witness testimony.

4. Failure to exchange expert opinion delays and impedes the enforcement process. The MBC/HQE enforcement process is routinely delayed and frustrated because, whereas MBC requires

its expert witnesses (physicians) to put their expert opinions in writing and shares them with the other side, defense counsel do not require their medical experts to put their expert opinions in writing and exchange them with MBC or HQE prior to the administrative hearing. This practice stifles the settlement process and often disadvantages the DAG at the hearing. In the *Initial Report*, the Monitor recommended that the Medical Practice Act be amended to provide that any party wishing to rely on expert testimony must reduce that expert testimony to writing and provide it to the other party well in advance of the administrative hearing.

5. Many of MBC's most important detection mechanisms are failing it. Despite the extensive "mandatory reporting scheme" set forth in section 800 *et seq*., the Medical Board is not receiving information to which it is statutorily entitled about civil judgments, settlements, and arbitration awards against physicians, criminal convictions against physicians, or hospital disciplinary (peer review) actions against physicians as required by law — information that enables MBC to detect possible physician wrongdoing, investigate, and take disciplinary action as appropriate. Further, physicians themselves routinely conceal information about their own misconduct from the Board through the insertion of so-called "regulatory gag clauses" — provisions that prohibit an injured plaintiff from complaining to or cooperating with the Medical Board — into civil malpractice settlement agreements. To ensure that the Medical Board is informed of events indicating potential physician incompetence or impairment, the Monitor proposed a number of new reporting requirements and the enhancement of several existing reporting requirements — including a DCA-sponsored educational program for courtroom clerks regarding their duty to report criminal convictions and civil judgments; the completion of a study of the hospital peer review process mandated in 2001, so that loopholes and problems in peer review reporting to MBC can be identified and closed; the imposition of penalties on insurance companies and physician employers that fail to report medical malpractice payouts as required by law; and a statutory ban on "regulatory gag clauses" in civil settlement agreements.

6. The Medical Board's public disclosure policy is insufficient. The Board's complex public disclosure statutes and regulations — which have evolved in patchwork-quilt style over the past decade — do not allow the Board to disclose sufficient information about physician conduct and history to enable patients to make informed decisions about their physicians. The Monitor recommended that the statutes governing public disclosure be streamlined to eliminate inconsistencies, redundancies, and drafting errors; and called for the required public disclosure of medical malpractice settlements over $30,000, misdemeanor criminal convictions against physicians that are "substantially related" to the duties of a physician, and significant terms and conditions of probation imposed by MBC.

7. The Board's Diversion Program — charged with monitoring substance-abusing physicians — is significantly flawed: Its most important monitoring mechanisms are failing,

it is chronically understaffed, and it exposes patients to unacceptable risks posed by physicians who abuse drugs and alcohol. The Monitor examined the Diversion Program's most important monitoring mechanisms — random drug testing, case manager attendance at group meetings of participants, and regular reporting by worksite monitors and treating psychotherapists — and found that all were failing. Further, the Diversion Program — due in part to severe understaffing — failed to detect or address these critical failures. Participants in the Program were not drug-tested as often as they should be; they were not terminated from the Program even after repeated violations; and no standards exist to guide the functioning of "worksite monitors" who purportedly oversee Program participants when they practice medicine. The Monitor found that the Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held; the Medical Board has failed to adequately supervise the Program; and the Program improperly operates in a vacuum that prevents MBC management from detecting breakdowns in its functioning.

The Monitor called on the Medical Board to reevaluate whether the "diversion" concept is feasible, possible, and consistent with MBC's "paramount" public protection priority. If the concept is deemed viable, the Monitor recommended that DMQ spearhead a comprehensive overhaul of the Diversion Program to correct longstanding deficiencies that have limited the Program's effectiveness in assisting participant recovery and in protecting the public. This overhaul must include not only additional staffing for the Program but also the adoption and enforcement of standards and criteria to which both Program participants and staff are consistently held. Additionally, the Monitor recommended that MBC more fully integrate and incorporate Diversion Program management into overall Board and enforcement program management, and ensure that the *Diversion Program Manual* — which is so outdated that it has become obsolete — is completely rewritten. Finally, the Monitor recommended that the Diversion Program — if it is continued and once its problems are addressed — be required to undergo a full performance audit by the Bureau of State Audits.

2005 REFORM LEGISLATION ADDRESSING THE MONITOR'S RECOMMENDATIONS

Most of the Monitor's *Initial Report* recommendations requiring legislation were amended into three bills considered by the California Legislature during 2005:

Senate Bill 231 (Figueroa). Most of the key recommendations contained in the Monitor's *Initial Report* were incorporated into SB 231 (Figueroa), which was introduced on February 15, 2005, and was substantively amended five times before it was finally signed by the Governor on October 7 (Chapter 674, Statutes of 2005). As enacted, SB 231 contains a mix of provisions. Many of them directly implement the Monitor's recommendations. Some of them only partially implement a Monitor recommendation; the compromise reflects the give-and-take of the political process as the bill moved through various committees and both houses of the Legislature and was ultimately

negotiated with the Schwarzenegger administration late in the process. Other provisions in SB 231 did not originate with the Monitor at all, but reflect the desires of MBC, the California Medical Association (CMA), or the Schwarzenegger administration.

As described in detail below, SB 231 (1) fundamentally restructures MBC/HQE investigations and prosecutions by implementing the vertical prosecution model, and paves the way for the prospective transfer of MBC's investigators to HQE after a transition period and legislative review in 2007; (2) enhances MBC's enforcement resources by increasing MBC licensing fees by 30%; (3) addresses excessive delays in the medical records procurement process by authorizing MBC to issue citations and fines for noncompliance with lawful MBC requests for medical records; (4) requires parties in MBC disciplinary proceedings to exchange expert witness opinion information prior to the evidentiary hearing; (5) improves MBC's ability to detect physician negligence and misconduct by enhancing several of its mandatory reporting requirements; (6) strengthens MBC's public disclosure policy and requires the Little Hoover Commission to study the effectiveness of MBC's public disclosure statutes and regulations; and (7) requests a thorough performance audit of MBC's Diversion Program and establishes a sunset date on which it will cease to exist if the Medical Board does not substantially improve it.

As MBC's "sunset bill," SB 231 also extends the existence of the Medical Board and its executive director position until July 1, 2010. Finally, although the Enforcement Monitor project ends on November 1, 2005, SB 231 requires a number of additional studies, hearings, and reports on various issues related to MBC's enforcement program. Chapter IV contains a chart outlining numerous post-Monitor activities related to MBC's enforcement program.

AB 446 (Negrete McLeod). In the *Initial Report*, the Monitor urged the Legislature to ban regulatory gag clauses — provisions included in civil settlement agreements that prohibit an injured victim from filing a complaint about the physician with MBC or otherwise cooperating with an MBC investigation, or requiring the victim to withdraw a complaint pending before MBC. AB 446 (Negrete McLeod), introduced during 2005, would have replicated a 20-year-old statutory precedent applicable to attorneys and banned the use of gag clauses by all DCA licensees — including physicians. Although AB 446 was fully supported by MBC and other agencies, the Governor vetoed the bill on September 29.

Senate Bill 1111 (Committee on Business, Professions and Economic Development), which was passed by the Legislature and signed by the Governor (Chapter 621, Statutes of 2005), is a technical clean-up bill that amends section 2230 to correctly reflect the number of members on DMQ's panels.

MBC'S ENFORCEMENT PROGRAM: THRESHOLD CONCERNS

In the *Initial Report*, the Monitor identified several threshold concerns about MBC's enforcement program. The following summarizes those concerns and documents the responses implemented by MBC, HQE, and the Legislature during 2005.

1. The enforcement process simply takes too long to protect the public. During 2003–04, the average length of time for a serious complaint to reach its disciplinary conclusion was 2.63 years. During 2004–05, MBC cut that overall average time slightly to 2.5 years, even without the addition of new monetary resources or staffing. Although MBC should be commended for its efforts, 2.5 years is excessive in light of the risk of irreparable harm posed by incompetent physicians, and the Board's investigative time still exceeds the 180-day goal established in section 2319.

2. MBC resources are inadequate. In the *Initial Report*, the Monitor noted that physician licensing fees — which support MBC's enforcement program — had not been increased since January 1994, working a 28% decrease in spending power since that time. In addition to the loss of budgetary resources, MBC's human resources were hit hard by staffing cuts required by the state's 2001–04 hiring freeze. In 2004, MBC estimated that it would need an increase in licensing fees from $610 to $800 biennially to support the reinstatement of lost enforcement positions and a restoration of service levels comparable to 1994; the Monitor agreed.

SB 231 increases MBC's initial and biennial renewal licensing fees to a base fee of $790 ($395 per year). At the request of CMA, the bill eliminates MBC's "cost recovery" authority under section 125.3 but requires this change to be "revenue neutral" to MBC. Thus, SB 231 permits MBC to increase licensing fees above the $790 base to compensate for the loss of cost recovery revenue, and to cover any "uptick" in investigative and other enforcement costs that accompanies the elimination of cost recovery. SB 231 also permits MBC to increase licensing fees by an additional $20 per biennial renewal period if its investigators are transferred to HQE after 2007.

SB 231's fee increase will enable the Board to restore fifteen investigator positions, six DAG positions, and MBC's Medical Director position — all of which were lost in the hiring freeze; implement vertical prosecution; augment the staffing of the chronically understaffed Diversion Program; maintain an adequate budget for the payment of qualified expert reviewers; restore lost medical consultant hours; and maintain a two-month reserve fund as required by law.

The resources battle is only halfway won. Armed with the fee increase, MBC and HQE must now submit budget change proposals (BCPs) to restore their lost positions and spend the new money in a way that not only restores 1994 service levels but significantly improves on them. The Monitor

urges the Department of Consumer Affairs, the Department of Finance, and other control agencies to approve these vitally important BCPs.

3. MBC and HQE's management structure and information systems need improvement. During 2005, MBC and HQE addressed several *Initial Report* concerns about MBC/HQE management structure and information systems:

■ ***Medical Director position***. As noted above, MBC lost its Medical Director position in the hiring freeze, and the Monitor urged the Board to reinstate the position. MBC agreed, and can fund the new position with SB 231's fee increase. The Monitor urges the Administration to approve the reinstatement of this important position.

■ ***Diversion Program management***. In the *Initial Report*, the Monitor observed that MBC has traditionally permitted its Diversion Program to effectively function in a vacuum, separate from overall MBC management. Because this separation resulted in breakdowns in key Diversion functions that pose a risk not only to the public but also to the physicians participating in the Program, the Monitor recommended that the administration of the Diversion Program be more fully integrated into MBC management. MBC has made progress on this issue. Since the issuance of the *Initial Report*, MBC management has hired a new program administrator who has strong enforcement and impairment program credentials, added a new case manager supervisor position to the Program, and expanded its vitally necessary Collection System Manager position into a full-time position. Additionally, MBC has created a new Diversion Committee and charged it with addressing longstanding policy issues that have plagued the Diversion Program.

■ ***Relationship between MBC and HQE***. MBC's investigations and prosecutions are inefficiently fragmented between two agencies, whereas most other comparable law enforcement agencies employ both investigators and prosecutors who work together in "vertical prosecution" teams under the direction of the prosecutor to gather evidence, assess the strength of the case, and quickly close weak cases while focusing expedited attention on meritorious cases. SB 231 imposes the essential elements of vertical prosecution on MBC and HQE — early assignment of an attorney/investigator team, continuity of teamwork throughout the life of a case, and early designation of trial counsel under whose direction the investigation proceeds. While SB 231 did not succeed in transferring MBC's investigators into HQE for full implementation of vertical prosecution, it has set the stage for the transfer (including the funding), and the Monitor anticipates that transfer will occur in 2008 after completion of this transition period.

■ ***Enforcement policy/procedure manuals***. In researching the *Initial Report* during 2004, the Monitor scoured a dozen MBC policy and procedure manuals, and found that several had not been updated to reflect 2002 legislative changes. MBC has made progress in this area as well. MBC

has revised its *Expert Reviewer Guidelines, Enforcement Program General Operations Manual, Enforcement Operations Manual, Central Complaint Unit Procedure Manual, Probation Operations Manual*, and *Investigation Activity Report Intranet Users' Guide*. MBC's *Citation and Fine Program Procedure Manual* was completely rewritten, and an overhaul of the *Diversion Program Manual* is under way.

■ ***Management information systems***. Although MBC continues to struggle with DCA's "Consumer Affairs System" (CAS) mainframe computer program, it is fortunate to have an in-house Information Systems Branch (ISB) that is capable of designing new software to accommodate specialized programs. For example, after the release of the *Initial Report*, ISB revamped the Diversion Tracking System (DTS) into a Web-based real-time program that was operational by July 1, 2005.

HQE now has one year of experience with its new ProLaw case management system. HQE and its prosecutors appear to have mastered the case tracking system aspect of ProLaw in that all HQE attorneys (since July 14, 2004) now track their time and tasks performed on MBC cases on ProLaw. Additionally, HQE managers have begun to request and receive simple reports. However, HQE appears to have made less effective use of other important capabilities of this system. The Monitor recommends that HQE take full advantage of its new ProLaw system by learning its capabilities, adding a field that will identify "priority cases" under section 2220.05, ensuring that ProLaw's calculation function is activated, and ensuring the data needed to calculate desired averages or totals are properly input by HQE staff on all cases.

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

In the *Initial Report*, the Monitor identified several concerns about MBC's Central Complaint Unit, which receives and screens complaints and reports about physicians — both "quality of care" (QC) and "physician conduct" (PC) cases — to determine whether they merit formal investigation. The following summarizes those concerns and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. CCU's average complaint processing time is longer than historically reported. In the *Initial Report*, the Monitor noted that MBC had been counting as "complaints" several categories of information that should not be counted as complaints — including "notices of intent (NOI) to sue" under Code of Civil Procedure (CCP) section 364.1, copies of insurer reports of malpractice payouts sent to the National Practitioner Data Bank (NPDB), and "change of address citations." As a result, CCU's reported complaint total was artificially high and its reported average complaint processing time was artificially low. During 2003–04, MBC discontinued counting NOIs and NPDB reports as complaints; during 2004–05, MBC discontinued counting change of address citations as

complaints. Thus, MBC has fully implemented the Monitor's recommendations and is accurately reporting both its complaint/report intake and its average case cycle times. Related to this issue, the Monitor recommended that CCP section 364.1 be repealed, as these reports provide MBC with information that is of little or no use. Effective January 1, 2006, section 20 of SB 231 (Figueroa) repeals section 364.1.

2. CCU's complaint processing takes too long. During 2003–04, it took CCU an average of 79 days (2.63 months) from receipt of a complaint to its closure or referral to the field for investigation — 12 days longer than it took CCU to process complaints in 2002–03. During 2004–05, CCU lowered its overall average complaint processing time to 66 days (2.2 months) — an encouraging 16% decrease.

CCU also lowered the average time it takes to process QC complaints — which involve the request, receipt, and analysis of medical records — from 140 days in 2003–04 to 122 days in 2004–05, a 13% decrease. CCU accomplished this reduction by working with its assigned DAG to revise the *CCU Procedure Manual* to emphasize the statutory timeframes for production of requested medical records; CCU also revamped the request letters it sends to physicians and medical facilities to include a citation to the relevant statute, a copy of the statute, and a reference to possible penalties for noncompliance. CCU's focus on prompt medical records procurement has cut last year's average medical records procurement delay in QC cases from 66 days to 48 days.

Although the Monitor suggested an expansion of the role of the assigned CCU DAG, that was not achieved during 2004–05. HQE's staffing losses and overall workload required HQE, in May 2005, to return the assigned CCU DAG to its Sacramento office for accusation filing and trial work. HQE hopes to reinstate the DAG in CCU by January 1, 2006, and also hopes — with the fee increase in SB 231 — to assign a DAG full-time to CCU (or to assign two DAGs half-time to CCU) to assist with case disposition review, medical records procurement, and stubborn issues related to malpractice payout reporting by insurance companies and physician employers.

3. CCU's implementation of the specialty review requirement for QC complaints has caused a number of problems. In the *Initial Report*, the Monitor found that MBC's implementation of section 2220.08 — which requires CCU to ensure that QC complaints have been reviewed by a physician with expertise in the same specialty as the complained-of physician — was causing substantial delay in the processing of QC cases in certain specialties. The Monitor made three recommendations relating to specialty review, two of which were implemented during 2005. First, MBC has developed a protocol for utilizing a qualified alternative medical reviewer in some cases where a subspecialist cannot be found to review a complaint after a 30-day good faith search. Second, section 12 of SB 231 (Figueroa) exempts from the section 2220.08 specialty review requirement new complaints against physicians who are already under investigation, the subject of a pending accusation, or on probation.

MBC postponed consideration of the Monitor's third recommendation — a statutory exemption from the specialty review requirement for cases where MBC is unable to locate a specialist after a good-faith 30-day search — based on representations by enforcement staff that CCU was developing the protocol described above, and that CCU had successfully recruited and trained a sufficient number of specialty reviewers such that the average time delay had declined significantly. However, new data indicate that the delay due to the specialty review requirement — an average of 45 days in 2003, sharply increasing to 67 days in 2004, and easing back to 53 days in 2005 to date — is still significant. MBC should continue to focus efforts on reducing the delay due to the specialty review requirement.

4. The codification of mandatory case processing priorities is resulting in unintended consequences. Section 2220.05 requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." The statute says that complaints falling into one of five stated categories (coded "U1–U5" by MBC) — which attempt to capture physicians "representing the greatest threat of harm" — should be handled on a priority basis. Although no one quarrels with this sound goal, the *Initial Report* documented several unintended consequences related to this requirement, including overuse of the U1 priority; lower enforcement priority for cases posing imminent risk (such as complaints regarding sexual misconduct and drug/alcohol abuse), and very low priority for economic harm cases (such as fraud and deceptive business practices). Although the Monitor recommended a collaborative effort to redraft the language of section 2220.05 to address these issues, MBC's Enforcement Committee deferred this issue for at least a year. In the meantime, the Committee directed staff to (1) gather data on the impact of section 2220.05; (2) develop a policy statement on staff's interpretation and implementation of the statute; (3) attempt to define the statutory term "serious bodily injury"; and (4) recommend whether additional categories of priority cases should be added to the statute.

5. Many of MBC's most important detection mechanisms are failing it. The *Initial Report* described several important "mandatory reporting requirements" intended to ensure that MBC is apprized of and can detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. However, several of these detection mechanisms are failing the Board and the public.

■ ***Malpractice Payouts***. Although sections 801 and 801.1 require insurance carriers and employers of physicians to notify the Board of malpractice payouts, many reports are not filed within the required 30-day time period, are incomplete, are useless to the Board (for example, many fail to identify the plaintiff in the malpractice action or the physician(s) whose conduct resulted in the payout), or are not filed at all. Further, MBC and HQE contend that malpractice action documents required to be forwarded to MBC under section 804 are often destroyed. In the *Initial Report*, the

Monitor noted that, unlike section 805 applicable to hospitals' reporting of peer review disciplinary actions against physicians, sections 801/801.1 contain no penalty whatsoever for failure to report, and recommended that they be amended to include substantial penalties for noncompliance.

This is one of the few Monitor recommendations requiring legislation that was neither addressed in SB 231 (Figueroa) nor meaningfully discussed by the Medical Board in the past year. The *Final Report* documents a 31% decrease in insurer/employer reporting of malpractice payouts to MBC over the past six years, and analyzes numerous examples of insurer/employer reports that are late, incomplete, or that blatantly violate the letter and/or the spirit of the reporting requirement. Both the Monitor and CCU staff have alerted MBC and HQE to this problem for over one year, but the loss of MBC enforcement staff, the recent absence of the assigned CCU DAG (although required by Government Code section 12529.5), and the separation of MBC and HQE have combined to contribute to the stalemate on this issue.

Insurer/employer failure or refusal to provide MBC with this statutorily-required information is a serious and undeniable problem which has been tolerated for too long by the Board and HQE. The Monitor recommends that MBC and HQE formulate a working group to (1) review the examples described in this report and other examples that can readily be produced by CCU staff; (2) review and draft revisions to the statutory language to close loopholes, identify mandated reporters at insurance companies and physician employers of all types, and add substantial penalties for noncompliance to sections 801, 801.1, and 803.2; and (3) sponsor legislation enacting those amendments.

■ ***Coroner's Reports***. Although section 802.5 requires a coroner to file a report with MBC whenever the coroner "receives information" that a death may be the result of a physician's gross negligence or incompetence, MBC receives few coroner's reports — never more than 40 in a given year. In response to the Monitor's recommendation that MBC educate coroners about their reporting responsibilities, the Board's public information officer sent informational letters about section 802.5 to all coroners' offices. Additionally, MBC's enforcement chief made an hour-long presentation on MBC's enforcement program and the importance of compliance with section 802.5 at the annual meeting of the California State Coroners' Association.

■ ***Physician Self-Reporting of Criminal Convictions***. Although many misdemeanor criminal convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action, section 802.1 limits physician self-reporting of criminal convictions to felonies. In response to the Monitor's recommendation that physicians be required to self-report misdemeanor criminal convictions to MBC, section 5 of SB 231 amends Business and Professions Code section 802.1 to require physicians to self-report misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a

physician. This self-reporting requirement will be triggered after MBC compiles, and the Legislature enacts, a list of such substantially related criminal convictions.

■ ***Court Clerk Reporting***. Although section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC, few court clerks comply with these requirements. The Monitor recommended that DCA, on behalf of all of its agencies with mandatory reporting statutes, join with the Judicial Council to design an educational program for courtroom clerks to enhance their familiarity and compliance with these reporting requirements. During 2005, DCA's Public Affairs Office drafted an informative article regarding the various court clerk reporting requirements in the Business and Professions Code for publication in the Judicial Council's *Court News Online* electronic newsletter; additionally, DCA has created a "universal reporting form" that can be used by any court clerk to report criminal convictions and civil judgments against any DCA licensee to the Department. DCA is preparing to publish the article and post the reporting form on its Web site.

Related to the reporting of civil malpractice judgments, section 4 of SB 231 (Figueroa) amends section 802 to require physicians to self-report civil judgments in any amount to MBC.

■ ***Hospital Reporting of Adverse Peer Review Action***. Although section 805 reporting by hospitals, health care facilities, and HMOs about internal disciplinary action taken against physicians is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action, it is the greatest area of failure. In 2003–04, MBC received only 157 section 805 reports — and fully one-third of those were for actions taken by hospitals against a physician's privileges *after* the Medical Board disciplined the physician's license. The data for 2004–05 are similar: Of the 110 section 805 reports received, 23 reported peer review actions taken after MBC had disciplined the license of the physician. In the *Initial Report*, the Monitor recommended that a comprehensive study of the peer review process mandated in a 2001 statute be funded and completed as soon as possible, so that section 805 might be amended to conform its reporting requirements to the actual conduct of peer review in California. Section 6 of SB 231 (Figueroa) amends section 805.2 to require MBC to contract with an external entity to conduct the study mandated in 2001 by July 31, 2007. Under SB 231, "[c]ompletion of the peer review study . . . shall be among the highest priorities of the Medical Board of California."

■ ***Regulatory Gag Clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. In the *Initial Report*, the Monitor recommended that regulatory gag clauses be statutorily banned for all regulated trades and professions — and particularly for physicians in light of the irreparable harm doctors can cause. During 2005, Assemblymember Gloria Negrete McLeod introduced the Monitor's

recommendation as AB 446. Although the Legislature passed AB 446, the Governor vetoed it on September 29. Unfortunately, this veto preserves a discredited practice and undermines the purpose of occupational licensing agencies — which is to protect future unsuspecting consumers who were not a party to the settlement.

6. The staffing allocations of CCU's sections should be revisited. In the *Initial Report*, the Monitor noted that the staffing of CCU's QC and PC sections was based on the projection that MBC would receive more QC cases than PC cases. Because the reverse is true, the Monitor suggested that CCU revisit its staffing allocations and cross-train analysts so that certain kinds of urgent PC complaints that warrant immediate attention (*e.g.*, complaints of sexual misconduct and drug/alcohol abuse) do not get lost in the massive caseloads handled by the one CCU analyst trained to handle such matters. CCU has implemented the Monitor's recommendations by redirecting one analyst position from the QC Section to the PC Section, and by assigning that redirected analyst to urgent PC matters (such that two PC analysts now handle urgent PC complaints).

7. Detection of repeated negligent acts has improved, but could be enhanced. In the *Initial Report*, the Monitor noted that CCU had instituted a review process for QC complaints recommended for closure based on a "simple departure" finding. Under the review process, CCU determines whether the complained-of physician has been the subject of prior similar "simple departure" closures — such that the physician might be disciplined for repeated negligent acts under section 2234(c). The Monitor recommended that this review process be extended to PC cases as well, particularly cases alleging sexual misconduct or drug/alcohol abuse. During 2005, CCU implemented the Monitor's recommendation.

8. CCU should ensure that subject physicians are notified when complaints are closed. In the *Initial Report*, the Monitor suggested that MBC ensure that subject physicians are notified when complaints are closed, and that its procedure manuals reflect this policy. CCU has implemented this recommendation.

9. CCU should regularly review and update its procedure manuals. In the *Initial Report*, the Monitor recommended that CCU ensure that its procedure manuals are regularly reviewed and revised to conform to changes in the law and MBC policy, and that HQE personnel are involved in these revisions. CCU has implemented the Monitor's recommendation; during 2005, the Monitor received five sets of revisions to the *CCU Procedure Manual*.

FIELD INVESTIGATIONS: DISTRICT OFFICES

Through MBC district offices, investigators gather evidence concerning alleged violations, analyze that evidence with the assistance of MBC medical consultants and external expert witnesses,

and recommend whether the Board should institute disciplinary action. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's investigative process, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. MBC investigations are plagued by delays and excessive case cycle times. The Medical Board has consistently failed to comply with section 2319's statutory goals for the investigative process, including an average of six months total time from receipt of complaints to completion of investigations (one year for complex matters). Even with MBC investigator caseloads at a near-record low of 19 cases per investigator, MBC remains unable to comply with the six-month and one-year processing goals. The average elapsed time for an MBC investigation during 2004–05 was 259 days, up from a similarly-calculated 243 days in 2002–03, and down slightly from the 2003–04 figure of 261 days. Over 26% of these investigations still take an average of twelve months or more.

The *Initial Report* documented the multiple personnel and process issues contributing to these long cycle times, including the general difficulty of MBC cases; reductions in district office staff; losses of other valuable resources (such as medical consultant time); chronic investigator recruitment and retention challenges; a changed case mix toward greater complexity; and increased use of defense counsel by physicians. As recommended by the Monitor, the Medical Board has addressed both resource/structural problems and process weaknesses in order to significantly reduce the stubbornly long case cycle times in MBC investigations. As described below, the internal reforms already undertaken by MBC are beginning to bear fruit. Coupling these efforts with the even greater changes to be wrought by SB 231 — most notably the 30% increase in fee revenues and the advent of the vertical prosecution system of case processing, there is reason for optimism that case processing will be speeded. But there is still much to be done before MBC case delays are reduced to the levels set by statute.

2. Attorney/investigator coordination and teamwork is inadequate. As documented in the *Initial Report*, MBC investigators in the present system typically function without true, close coordination with the trial prosecutor who will ultimately handle the case. This system of limited investigator/trial attorney teamwork and cooperation — the "hand-off prosecution model"— stands in sharp contrast to the "vertical prosecution model" (where investigators and attorneys work together as a team throughout the life of a case) widely used in complex white collar crime and regulatory matters by many state, federal, and local agencies. In the *Initial Report*, the Monitor recommended that MBC's investigators be transferred to HQE and suggested that MBC and HQE convert to the vertical prosecution model.

The implementation of a contemporary vertical prosecution system — bringing MBC investigators and HQE prosecutors together into investigation and trial teams — is a centerpiece of

SB 231 (Figueroa). As amended on August 30, SB 231 would have transferred the Medical Board's investigators into HQE to enable full implementation of the vertical prosecution model. Although that version of the bill was supported by MBC, HQE, CMA, Kaiser Permanente, defense attorneys whose practices concentrate on physician defense, seven former Medical Board presidents, one former Medical Board executive director, Governor Pete Wilson's Department of Consumer Affairs Director, and the Federation of State Medical Boards, the Schwarzenegger administration opposed the transfer of MBC's investigators to HQE. Thus, the final language of SB 231 implements vertical prosecution without the immediate transfer of investigative staff. However, the bill envisions legislative reconsideration of the transfer during 2007, and contains funding for full implementation of vertical prosecution including the transfer.

Specifically, SB 231 adds new section 12529.6 to the Government Code, which makes legislative findings that because of the critical importance of MBC's enforcement function, "using a vertical prosecution model . . . is in the best interests of the people of California." Section 12529.6(b) requires that, as of January 1, 2006, each MBC complaint that is referred for investigation be "simultaneously and jointly" referred to an investigator/prosecutor team (including the prosecutor who will ultimately file and try the case) which will handle the matter for its duration. Under the direction of the prosecutor, the investigator will gather evidence that enables the prosecutor to advise MBC whether and how to proceed with formal disciplinary proceedings. MBC must report to the Legislature on the progress of the vertical prosecution model mandated in SB 231 by July 1, 2007, and all of the newly added provisions relating to vertical prosecution sunset on July 1, 2008 — meaning that during 2007, the Legislature will have another opportunity to evaluate the feasibility of the transfer of MBC's investigators to HQE and enact legislation mandating it.

In the meantime, SB 231 prepares MBC and HQE for the eventual transfer of MBC's investigators to HQE and full implementation of the vertical prosecution model. It transfers the investigative function to HQE; redefines "MBC investigations" as "HQE investigations"; eliminates the "deputy in district office" (DIDO) program under which HQE has been required to place prosecutors onsite at MBC district offices to provide legal guidance to investigators — this program will be unnecessary when MBC investigators are transferred to HQE; and authorizes MBC to increase its licensing fees to cover the additional costs of transferring its investigators to HQE.

If fully and successfully implemented, SB 231 will work a comprehensive change in the entire process through which MBC and HQE develop and resolve these disciplinary cases. In anticipation of the January 1, 2006 start of the vertical prosecution system, MBC and HQE officials have met and begun to comprehensively plan its implementation. The Monitor urges MBC and HQE to make full use of their opportunity to prove the value of the team approach. By doing so, they will earn the full and final implementation of this advantageous system of investigation and prosecution.

3. Delays in medical records procurement are chronic. In the *Initial Report*, the Monitor identified the medical records procurement step as one of the lengthiest components of the screening and investigative process. In fiscal year 2003–04, the average timeframe from a request for records by MBC investigators to the receipt of all records was 74 days (or 2.5 months), despite the statutory 15-day timeframe in Business and Professions Code sections 2225 and 2225.5. Combining the district offices' 74-day average with CCU's average 66-day records-gathering period, medical records procurement at MBC during 2003–04 consumed an average of 140 days — or 77% of the 180-day goal in section 2319. The Monitor found that lengthy delays by physicians in complying with medical records requests were being tolerated by both MBC investigators and HQE prosecutors; and urged MBC and HQE to agree upon, implement, and strictly enforce a new medical records procurement policy.

In response, MBC management amended *Enforcement Operations Manual* section 6.14 in January 2005 to advise all sworn staff that a "zero tolerance" policy had been initiated and that Board staff would no longer tolerate delays by physicians or hospitals in producing medical records requested pursuant to section 2225.5. The manual sets new deadlines for MBC investigators to secure patient releases and serve requests for records in person; requires close tracking of deadlines for production; and mandates expedited follow-up where records are not produced on time. As a direct result of these policy changes (which were communicated to the physician community and defense bar by HQE), MBC's 2004–05 average timeframe from a request for patient records by an MBC investigator to the receipt of those records was 44 days, down from 74 days in 2003–04 (a reduction of over 40%). Although this is significant improvement, the average timeframe is still more than twice the allowable statutory time period, so further reductions are important.

SB 231 (Figueroa) will assist in medical records procurement. The bill amends section 2225(d) to define the term "good cause" for delay and to extend the time within which physicians must produce requested medical records to 15 business days from the date of MBC's request. Thereafter, SB 231 authorizes MBC to use its existing citation and fine authority to penalize physicians immediately when they fail to produce requested medical records within 15 business days and without good cause. SB 231 specifies that the citation and fine remedy is in addition to other remedies available to MBC.

4. Subject interview policies are inconsistent and ineffective. MBC investigators must conduct subject interviews as a key part of the district office investigative process. In the *Initial Report*, the Monitor found that — during 2003–04 — an average of 60 days elapsed between MBC's request for an interview and the physician's appearance or refusal to appear, and recommended that MBC and HQE agree upon and consistently enforce a new policy requiring prompt physician cooperation with interview requests and regular tape-recording of interviews. In January 2005, enforcement staff revised *Enforcement Operations Manual* section 6.2 to institute new subject

interview policies and deadlines. Implementation of these new policies has somewhat reduced the interview delay: In 2004–05, the average time between initial request and actual subject interview was 57 days; the average time between request and interview refusal was 49 days. These figures are down slightly from the overall average of 60 days in 2003–04. However, they still represent a large portion of the undesirable 259-day average investigative timeframe.

5. Medical consultant availability, training, and utilization are inadequate. In the *Initial Report*, the Monitor noted that the availability of medical consultants is central to the speed and quality of QC case processing at the district office level; however, MBC budget constraints caused a 15% reduction in available medical consultant hours agencywide during 2003–04. This reduction has meant that medical consultants are often unavailable for or are greatly delayed in reviewing expert opinions and participating in decisions to transmit cases. The Monitor urged MBC to expand and improve its medical consultant program. As noted above, SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours.

6. Expert witness availability and use are systemic weaknesses. In the *Initial Report*, the Monitor found that MBC investigations continue to be delayed by the unavailability of experts (particularly highly specialized ones), inadequate training provided to new experts, and inconsistent performance by experts. These concerns are addressed in detail below.

7. Ongoing training of investigators, medical consultants, and experts is inadequate. During recent years, MBC — which in the past had an exemplary training program — was forced to substantially reduce formal training for investigators, medical consultants, experts, and others, to accommodate pressing budgetary concerns. The Monitor recommended that MBC continue to pursue the resources necessary to reinstate and improve its sequential training programs for which the agency was justifiably recognized in previous years. During 2004–05, MBC management has maintained and modestly expanded its training regimen. However, full implementation of the Monitor's training recommendations will require funds from the SB 231 budget augmentation. Especially worthy of consideration is the reinstatement of the senior-level training supervisor position which was a casualty of the 2001–04 budget cuts.

8. Coordination with state and local prosecutors is underutilized. Many of MBC's peace officer investigators have substantial knowledge of the criminal and civil law enforcement options available to the agency as potential tools to address complaints against medical practitioners involving both quality of care and physician conduct issues. However, the *Initial Report* noted the concerns of state and local prosecutors over the need for greater early communication and consistent coordination between MBC investigators and state and local law enforcement agencies in cases where non-administrative enforcement tools (such as Penal Code section 23 orders or civil unfair

competition actions) may be appropriate. The Monitor recommended that MBC make every effort to improve cooperation and case referrals between its enforcement staff and state and local prosecutors. MBC management and staff have implemented the Monitor's recommendation by actively participating in conferences and consumer protection roundtable meetings conducted by the California District Attorneys Association's Consumer Protection Committee; working on interagency enforcement cases with local, state, and federal authorities; and reaching out to numerous allied investigative and prosecution agencies in a wide variety of settings.

9. Recruitment and retention problems exacerbate MBC personnel shortages. Compounding the loss of 19 sworn investigator positions during the 2001–04 hiring freeze, MBC continues to lose highly trained and experienced investigators and well-qualified applicants to other agencies because of disparities between MBC investigator salaries and those at other agencies hiring peace officers. The Monitor urged MBC to continue its efforts to reinstate its lost enforcement program positions and to upgrade the salaries of its investigators commensurate with the competition.

The fee increase in SB 231 (Figueroa) satisfies the essential pre-condition for the restoration of these necessary MBC investigator positions — which are central to the successful implementation of the vertical prosecution system now declared in state law to be in the best interests of the public. The proposal to restore MBC investigator positions represents not a net growth in state government but a return to the 2001 level of staffing previously found to be essential. However, MBC cannot return to this minimally necessary staffing level without the cooperation of the Department of Consumer Affairs, the State and Consumer Services Agency, and the Department of Finance, which must ultimately approve budgets or BCPs for the hiring of MBC staff and the reinstatement of lost positions. The Monitor urges all those with authority over the budget process to permit the Medical Board to use these earmarked special funds for the purposes for which they are intended, including the restoration of the MBC investigative positions lost in recent years.

The related problems of investigator recruitment and retention can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature's affirmative approval after review of the 2007 report, the transfer of the MBC investigators to HQE will eventually result in special agent status for MBC's sworn personnel and a concomitant increase in pay and career recognition. Morale and productivity will be boosted, and MBC's ability to recruit and retain highly qualified investigators will be dramatically improved.

10. Procedural and training manuals must be updated continuously. The *Initial Report* expressed concern that MBC investigations and other enforcement processes were frequently guided by policy and procedure manuals that had not been consistently reviewed or approved by HQE —

MBC's legal counsel and enforcement partner. In addition, at least some of those manuals had not been adequately updated by MBC management and were, in at least a few cases, inaccurate as to Board policy. MBC has made progress in addressing this concern. The Board has continuously updated its *Enforcement Operations Manual* during this reporting period. Of equal significance, MBC has shared copies of its *Enforcement Operations Manual* with HQE management and supervisors for the first time in at least a decade, permitting an ongoing dialogue on enforcement policies and guidelines.

11. Investigators need full and easy access to law enforcement databases. The *Initial Report* noted that — due to budget woes — MBC investigators sometimes lack convenient access to law enforcement databases that are essential to modern police work. In response to the Monitor's recommendation that MBC improve investigator access to law enforcement information systems, the Board is exploring enhanced access to a number of databases. Some of these efforts and expenditures will become unnecessary following the proposed transfer of MBC investigators to HQE, where access to these systems is more readily available. This is one of the numerous efficiencies which would be realized by full integration of the MBC investigators and HQE prosecutors.

EXPERT REVIEWER PROGRAM

Through MBC's Expert Reviewer Program, the Board identifies and utilizes external physician experts to review evidence (including medical records) gathered in quality of care cases and opine whether the subject physician's conduct departed from applicable professional standards. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's Expert Reviewer Program, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. Average expert reviewer times are excessive. Once an expert is chosen for a given QC case and has received the investigative file (including medical records and other documentary evidence), the expert is expected to review the materials, draft a memorandum in a specified format, and return the file within 30 days. In the *Initial Report*, however, the Monitor found that the average 2003–04 turnaround time for expert opinions was 69 days. According to recent data from the Expert Reviewer Program, the average turnaround time in 2004–05 was also 69 days — over two times MBC's goal.

This delay occurs because most California physicians who provide expert review services to MBC are actively practicing medicine, and must find time to provide services to MBC outside their busy practices. It may also occur because MBC is able to pay only $100 per hour for records review and report preparation and $200 per hour for testimony at hearings — while physicians who

testify for the defense or in civil malpractice proceedings are routinely paid $500–$750 per hour, depending on the specialty. Although MBC could never pay its experts the equivalent of what they earn in medical practice, a growing number of experts indicate that MBC should attempt to increase the hourly rates. If the fee increase in SB 231 can accommodate an increase in the hourly rate paid for records review and report preparation, MBC should consider it as it may assist in the recruitment of qualified experts — who are essential to the Board's ability to prove a quality of care case — and may prompt experts to review cases in a more timely fashion.

2. There is a lack of qualified experts in many specialties, and the CCU specialty review requirement is siphoning off some experts who would otherwise review cases in the field. In the *Initial Report*, the Monitor noted that MBC lacks a sufficient number of experts in certain subspecialties, and that some of those experts are now being utilized by the Central Complaint Unit for the specialty review required by section 2220.08. The Monitor recommended that MBC undertake a vigorous recruitment effort and that — resources permitting — it should consider reinstating in-person training sessions for expert reviewers. During 2005, MBC enforcement staff implemented both of the Monitor's recommendations. Staff engaged in a concerted effort to recruit expert reviewers through an *Action Report* article and through presentations to physician groups and organizations. Additionally, staff identified specialties and subspecialties in which MBC lacks a sufficient number of experts — including dermatology, neurosurgery (especially spine surgery), pediatric surgery, pediatric cardiology, and gastric bypass surgery — and has engaged in a targeted outreach effort to hospital administrators and individual physicians in these specialties. Finally, MBC and HQE staff reinstituted in-person training sessions for expert reviewers which have been held in MBC district offices all over the state.

3. There is no requirement that expert testimony be reduced to writing and/or exchanged before the hearing. In the *Initial Report*, the Monitor explained that MBC requires its experts to reduce their expert opinions to writing, which written opinions are discoverable by the defense as soon as the accusation is filed. However, defense counsel frequently instruct their experts not to reduce their opinions to writing. Because of the Administrative Procedure Act's limitations on discovery in administrative proceedings, the HQE DAG frequently has no idea of the substance of defense counsel's expert opinion until that expert takes the stand at the evidentiary hearing. This practice results in the unfair "sandbagging" of the DAG at the hearing, and stifles the possibility of prehearing settlement. The Monitor urged that the Medical Practice Act be amended to provide that any party to a Medical Board enforcement matter that wishes to rely on expert testimony must reduce that testimony to writing and provide it to the other party well in advance of the hearing.

SB 231 (Figueroa) adds new section 2334 to the Business and Professions Code, which requires a party to a Medical Board disciplinary proceeding who wishes to rely on expert testimony to exchange certain information in writing with counsel for the other party: (1) a curriculum vitae

of the expert; (2) a brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis; (3) a representation that the expert has agreed to testify at the hearing; and (4) a statement of the expert's hourly and daily fee for providing testimony. The exchange of this information must occur at least 30 days prior to the commencement of the administrative hearing or as ordered by the ALJ. OAH is authorized to adopt regulations to implement section 2334.

4. The expert reviewer handbook contained errors. In the *Initial Report*, the Monitor noted that MBC's *Expert Reviewer Manual* provided to the Monitor team in 2003 had not been revised to conform to the changes in 2002's SB 1950 (Figueroa) and contained several legal errors. That manual was revised and corrected in late 2004.

PROSECUTIONS: HEALTH QUALITY ENFORCEMENT SECTION

The Health Quality Enforcement Section of the Attorney General's Office houses the prosecutors who represent MBC in disciplinary actions against its licensees; they review investigations, prepare and file accusations and other pleadings, try cases at evidentiary hearings, and represent DMQ if its disciplinary decision is challenged. The following summarizes the Monitor's *Initial Report* findings about the performance of HQE, and documents the responses to those findings implemented by the Attorney General's Office, the Medical Board, and the Legislature during 2005.

1. HQE cycle times remain lengthy, including recent increases in the filing phase. Without increased staff or improved process efficiency, HQE continues to experience lengthy case processing times, notwithstanding the efforts of a group of experienced and hardworking DAGs and supervisors. MBC statistics for fiscal year 2004–05 reveal an average 116-day period between transmittal of the completed investigation by MBC and the filing of the accusation, up from 107 days last year and 60–70 days in 2001, before HQE staffing shortages took hold. The Monitor's primary recommendation to address long case cycle times and case efficiency concerns — the successful implementation of the vertical prosecution system, beginning January 1, 2006 — is discussed above in "Field Investigations."

2. HQE attorney staffing is insufficient to meet its statutory and operational requirements. Although Government Code section 12529(c) requires HQE to be "staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions," HQE's six offices suffered a 15% loss of attorney positions in the past four years, and no remedy has been forthcoming. HQE's staffing losses are now exacerbated by a number of vacancies in established attorney positions. In a September 2005 letter to Attorney General Bill Lockyer, Medical Board President Ronald Wender, M.D., directed attention

to the vacancies in HQE which are "causing delays in filing accusations and setting matters for hearing, and therefore, impacting public protection." Dr. Wender urged the Attorney General to "move quickly to fill all vacant positions in this vital section of the Attorney General's Office." The Monitor fully endorses that recommendation, and adds that success in implementing vertical prosecution, and in reducing disciplinary delays generally, will almost certainly depend on filling vacant attorney positions and ending HQE understaffing. As noted above, SB 231 increases physician licensing fees by 30%, and a portion of those increased revenues has been earmarked for reinstatement of lost DAG positions. The Monitor urges relevant control agencies to approve the creation of these positions which are now vital to the success of vertical prosecution.

3. Attorney/investigator coordination and teamwork is inadequate. As described above, the traditional system linking HQE prosecutors with MBC investigators has been and still is characterized by inadequate coordination and teamwork. HQE prosecutors still generally receive "hand-off" cases which have been investigated and assembled by MBC investigators with little or no input from the HQE trial prosecutor who will handle the case. Most HQE prosecutors complain that they do not play a role in shaping the cases they receive or the investigative plans and strategies behind them, often resulting in last-minute changes of case direction, amended pleadings, and delays as cases are reinvestigated. Equally critical, HQE DAGs today frequently have little or no investigator assistance at the hearing itself. In the *Initial Report*, the Monitor called for a sweeping reform of the basic model of MBC and HQE disciplinary interaction with the implementation of the vertical prosecution system. The enactment of SB 231 (Figueroa), detailed above, mandates the implementation of the vertical prosecution model by January 1, 2006, and provides the mechanism for full integration of MBC's investigators and supervising investigators into HQE by 2008 if the initial implementation is adjudged successful by the Legislature.

4. Attorney assistance is not used sufficiently in MBC's medical records procurement process. The *Initial Report* expressed concern that HQE prosecutors seldom file subpoena enforcement actions or motions for sanctions for failure to produce medical records, contributing to the laxity in physician and institutional responses to MBC requests for medical records. The Monitor urged MBC and HQE to revise their medical records procurement and enforcement policies to ensure prompt compliance with records requests.

HQE management has embraced these recommendations, supported MBC's policy of rigor with regard to records production, and encouraged its staff attorneys to make more frequent and aggressive use of existing sanctions and procedures to ensure records production. In March 2005, following MBC's formulation of its vigorous new "zero tolerance" policy, HQE management sent letters to defense counsel and various professional organizations advising them of the Board's new policy requiring adherence to sections 2225 and 2225.5. HQE staff has also responded with increased enforcement actions. Subpoena enforcement actions for medical records sought in fiscal

year 2003–04 totaled only four statewide; HQE increased this figure to nine in 2004–05. No motions for sanctions for failure to produce were brought by HQE attorneys in 2003–04; HQE staff filed three such motions in 2004–05. HQE's high-visibility enforcement notices and increased case activity no doubt played a role in the reduction of average document production times in the MBC district offices from 74 days in 2003–04 to 44 days in 2004–05.

5. HQE and MBC make inadequate use of ISO/TRO powers and the Penal Code section 23 authority. The *Initial Report* called attention to the relatively modest use of legal tools available to MBC and HQE when a physician is an imminent danger to the public and continues to practice medicine. The use of important expedited proceedings — including interim suspension orders (ISOs), temporary restraining orders (TROs), and probation order proceedings under Penal Code section 23 — has declined in recent years. The Monitor recommended that MBC and HQE make more extensive use of these potent tools. In response to this recommendation, HQE stepped up its use of these proceedings. Motions for ISO/TRO increased to 40 in fiscal year 2004–05 — a 50% increase. Although the number of Penal Code section 23 probation orders sought decreased to nine (of which seven were successful), this decline was largely due to the new procedural requirements imposed by the appellate court decision in *Gray v. Superior Court*. The Monitor believes that early trial attorney involvement in the investigation — an integral part of the new vertical prosecution system under SB 231 — will result in increased use of these important tools for public safety.

6. Needed improvements in HQE case tracking and management information systems have begun and must be properly implemented. During the summer of 2004, HQE implemented the long-awaited ProLaw management information system. HQE supervisors report that the system works well for basic case tracking and management review. However, several desirable capabilities are not yet in place, including the ability to perform calculations of key data for management purposes (such as case cycle times and average caseloads), the ability to trace referrals to other prosecuting agencies, and a method of noting case priorities under section 2220.05. Further development of ProLaw should continue to be a priority for HQE.

7. HQE has no formal policy and procedure manual to ensure uniformity and assist in training. The *Initial Report* noted that HQE has no formal policy/procedure manual or operations manual in place to clearly reflect its functions and processes, leading to diverging policies, inconsistent practices, and a weakened training process. In response to the Monitor's recommendation, HQE management began a process aimed at outlining and then drafting an HQE operations manual. However, the supervening enactment of SB 231 provides a tremendous opportunity to advance this project in the broader context of the vertical prosecution system — and the Monitor now recommends that MBC and HQE develop a joint operations manual implementing vertical prosecution. The Monitor believes the distribution of this joint manual would have

immediate practical and symbolic significance, and should be among the highest priority projects for HQE and MBC in the near term.

8. The current venue statute for adjudicative hearings results in substantial and unnecessary costs for HQE, OAH, MBC and — ultimately — disciplined physicians and the physician population generally. In the *Initial Report*, the Monitor found that Government Code section 11508 — which generally assigns the venue for administrative hearings to the judicial district in which the transaction in question occurred or where the respondent resides — has frequently required the costly scheduling of administrative hearings in cities in which HQE and OAH have no office or hearing facilities. The Monitor urged the amendment of section 11508 to require adjudicative hearings to be held in large cities in which HQE has offices and OAH has courtroom facilities. Section 22 of SB 231 amends Government Code section 11508(a) to require that MBC administrative hearings be held at the OAH facility closest to the location where the transaction occurred or the respondent resides. Defense concerns are fairly addressed, in that section 11508(c) retains the respondent's ability to move for change of venue and the ALJ's discretion to order a venue change. However, absent good cause to the contrary identified in writing by the ALJ, hearings must now take place in a facility maintained by OAH. This will significantly change the wasteful practice under prior section 11508 and yield a clear public benefit.

HEARINGS: MEDICAL QUALITY HEARING PANEL

The Office of Administrative Hearings (OAH) is a centralized panel of administrative law judges (ALJs) who preside over state and local agency adjudicative hearings in a variety of areas. In 1993, a special panel of ALJs called the Medical Quality Hearing Panel (MQHP) was created in OAH; ALJs appointed to the MQHP are permitted to specialize in physician discipline matters. The law requires an MQHP ALJ to preside over MBC evidentiary hearings. In the *Initial Report*, the Monitor made no findings regarding OAH's performance. However, the Monitor promised to look into the following issues.

1. OAH was impacted by the hiring freeze and budget cuts. In the *Initial Report*, the Monitor noted that OAH was not immune from the October 2001 hiring freeze or the subsequent position "sweeps" and budget cuts. OAH lost two ALJ positions and a number of support staff positions. Although these losses affected OAH as a whole, they did not directly impact the MQHP which provides services to MBC. The MQHP remains staffed with 13 line ALJs, which appears sufficient to handle MBC's workload.

2. The time it takes to schedule and conduct evidentiary hearings is lengthy. In July 2004, OAH adopted a new policy requiring it to calendar hearings to start within 90 days of the date both parties are available; in no event will the first day of the hearing be scheduled more than 210

days from the date OAH receives the request for hearing. Despite this new policy, an average of 382 days elapsed between the filing of the accusation and the conclusion of the evidentiary hearing during 2004–05 (down from 448 days in 2003–04). Some of these hearings are one- or two-day matters; others should last days or weeks but — due to the schedules of the attorneys, respondent, and judge — must be conducted in non-contiguous blocks over the course of many months. It appears that the delay in scheduling and conducting MBC hearings is not due to a shortage of judges or bureaucratic limitations on OAH's part; instead, the understaffing in HQE's Los Angeles office (which normally files approximately 60% of all accusations in California) and the limited number of defense counsel who regularly defend physicians in MBC disciplinary matters account for much of the delay in scheduling and holding hearings. In OAH's view, it has sufficient MQHP ALJs to hear cases more rapidly than they are being heard — but they can't, due to a shortage of attorneys in HQE and the limited number of defense attorneys who handle MBC cases.

3. DMQ members perceive that MQHP ALJs are not following MBC disciplinary guidelines. During 2001–02 and 2002–03, DMQ nonadopted an unusually high number of proposed ALJ decisions: 25% in 2001–02 and 28% in 2002–03. However, the nonadoption rate declined to 16% in 2003–04, and further decreased to only 11% in 2004–05. According to the OAH director, DMQ nonadopts a larger percentage of proposed decisions than do other agencies, which generally nonadopt approximately 5% of proposed decisions. The reasons for this higher nonadoption rate are unclear. Although DMQ members have at times voiced concerns that ALJs do not follow the Board's disciplinary guidelines when recommending discipline in physician cases, it is clear that DMQ agrees with the ALJs' proposed decisions in the vast majority of cases.

4. Whether ALJs are receiving medical training as authorized by Government Code section 11371 is unclear. According to the OAH director, MQHP ALJs receive medical training in a variety of ways. In November 2004, the director convened a three-day annual statewide training session for OAH ALJs, and more than one-third of it related to medical issues (including participation and presentations by Medical Board staff). In addition, every month, every OAH office has a staff meeting which often includes a training component; some of those training components relate to Medical Board issues. Finally, MBC staff has visited all four OAH offices in the past year to engage in half-day training sessions with MQHP ALJs. While MBC staff members are prohibited from addressing issues raised in specific or ongoing cases, they provide valuable information on a list of topics of interest to MQHP ALJs.

5. ALJs rarely make use of their authority to call their own expert witnesses. Under Government Code section 11371(d), MQHP ALJs — if confronted with diametrically opposed expert witnesses paid by the parties — are authorized to call their own expert to the stand "to testify on the record about any matter relevant to a proceeding and subject to cross-examination by all

parties." According to the OAH director, this procedure is rarely used, primarily because the judges depend on the parties to produce relevant expert testimony and generally feel comfortable relying on it. Further, if the judge were to select his/her own expert, the use of that expert would delay the proceeding by several additional months. For these reasons, this mechanism is seldom used.

6. Should ALJs be authorized to enforce administrative subpoenas? As noted throughout the *Initial Report*, medical records procurement and MBC/HQE's tolerance of lengthy delays by physicians in producing requested medical records are serious issues confronting MBC and HQE. One time-consuming aspect of the existing process is that subpoena enforcement is available only in superior court. In the *Initial Report*, the Monitor suggested that some thought be given to authorizing MQHP ALJs to enforce subpoenas issued by MBC, as a means of expediting medical records procurement. While this is a possibility, enabling legislation would be required and it is not clear whether the MQHP is sufficiently staffed to undertake such a function. Hopefully, MBC's new medical records procurement policy and SB 231's expansion of the citation and fine sanction to noncompliance with lawful requests for records will substantially shorten the timeframe necessary for medical records procurement and obviate the need for subpoena enforcement proceedings by either superior courts or OAH ALJs.

DECISIONS: DIVISION OF MEDICAL QUALITY

MBC's 14-member Division of Medical Quality is divided into two seven-member panels that review proposed ALJ decisions and stipulated settlements negotiated between MBC/HQE and respondent physicians. The following summarizes the Monitor's *Initial Report* findings and concerns about DMQ review of proposed disciplinary dispositions, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. The added value of DMQ review of proposed decisions is unclear. In the *Initial Report*, the Monitor noted that, on three prior occasions, legislation has been attempted that would eliminate DMQ review of proposed decisions in favor of permitting the ALJ to make the final agency decision based on the agency's disciplinary guidelines and subject to a petition for judicial review by either side. According to the Monitor, the prior attempts to eliminate DMQ review of proposed decisions were intended to achieve two goals: (1) streamline the decisionmaking process to expedite it for the benefit of both the respondent and the public; and (2) create a limited number of decisionmakers who have both (a) subject matter expertise and (b) independence from the profession — as opposed to the current time-consuming and expensive system where layer after layer after layer of decisionmakers are required to sequentially learn the details of a disciplinary matter.

The Monitor then examined the "qualifications" of the various decisionmakers in the existing process. The MQHP ALJ — a professional judge who is trained in the law and experienced in the

judicial process — is present at the evidentiary hearing, has seen and heard the witnesses, has received all the documentary evidence, and has heard the expert testimony submitted by both sides. The judge specializes in physician discipline matters and is familiar with the rules of procedure and evidence in administrative proceedings. Thus, the judge has both knowledge of the evidence and is independent of the profession. On the other hand, DMQ members are physicians and other professionals who meet once every three months for two days; they are generally not lawyers or judges, and may have no familiarity with the rules of evidence or administrative procedure. When DMQ members receive a proposed decision in the mail, that is all they have — they have no access to the transcript of the hearing or the evidence presented at the hearing. Unlike jurors in a civil or criminal trial, DMQ members are not present at the hearing. They have had no opportunity to observe the witnesses or judge their credibility and demeanor. They may not have any familiarity with the subject matter of the particular case; usually have no idea how similar cases have been decided in the past; and often hold the same license as the accused licensee — such that they may have (or may be perceived to have) empathy for or bias against their accused colleague. While DMQ physician members may have medical expertise in a particular specialty, it may not be relevant to the case at hand; in any event, DMQ is confined to the evidence in the record — including the expert testimony of physicians who practice in the same specialty as the accused, have thoroughly examined the evidence, and have been subject to cross-examination.

In the *Initial Report*, the Monitor questioned the value of DMQ review and noted that the cost of the current system — including time, money, and lost opportunity costs — seems to outweigh the system's output: the nonadoption of very few proposed decisions (only 7 out of 63 in 2004–05) and the rejection of very few stipulations (only 18 out of 223 in 2004–05). The Monitor recommended that DMQ engage in a public dialogue on the value and costs of DMQ review of proposed decisions.

At its April 22, 2005 meeting, the Board's Enforcement Committee commenced a very preliminary discussion of this issue. The Committee received a background paper from staff outlining possible options, and heard brief public comment on the matter. Finding that this issue does not appear to require urgent action, the Committee voted to defer this matter until 2006.

2. The consistency of DMQ decisionmaking is unclear. In the *Initial Report*, the Monitor noted that the fragmented structure of MBC's enforcement program makes it difficult to evaluate the consistency of decisionmaking at any point in the process, including DMQ review. Investigations are handled from eleven different MBC offices; they are funneled into one of six HQE offices and thereafter into one of four OAH offices. Decisionmaking occurs at each of these steps — decisions to close cases, to move them further in the process, to seek disciplinary action, to impose disciplinary action. DMQ decisionmaking is superimposed on all the decisionmaking that occurs below, and it is also plagued with fragmentation. DMQ is split into two panels, neither of which knows of the other's decisionmaking in similar cases. DMQ membership is constantly

shifting and changing. There is little or no *stare decisis* — the legal doctrine under which courts adhere to precedent (prior decisionmaking in similar cases) on questions of law in order to ensure certainty, consistency, and stability in the administration of justice — in administrative agency proceedings.

Compounding this problem of is DMQ's failure to utilize Government Code section 11425.60's "precedent decision" mechanism. Although this ten-year-old mechanism is intended to promote consistency in decisionmaking, encourage settlements, and avoid costly litigation, DMQ has made no use of it other than to discuss its existence at its July 2004 meeting. The Monitor suggested that DMQ more fully explore its "precedent decision" authority and begin to utilize it. In response to this recommendation, DMQ staff says it continuously reviews each final disciplinary decision to determine whether it may be appropriate for designation as a precedent decision.

3. The procedure used at DMQ oral arguments is flawed. When DMQ nonadopts a proposed decision, it is required to afford the parties an opportunity for oral argument before making its final decision. DMQ's oral argument proceedings are most unusual. The primary reason for a nonadoption is that DMQ is considering a harsher penalty than that recommended by the ALJ; thus, the respondent physician is turned into a petitioner. That respondent must be mystified when he arrives at the hearing to find that the Board is represented by its own counsel — HQE. In effect, the "client" hears argument from its own counsel, with which it frequently interacts and upon whom it depends for legal advice on a myriad of matters.

MBC regulations require an ALJ to preside over oral arguments, to ensure that someone legally trained is available to rule on evidentiary objections, require counsel and the respondent to stick to evidence that was admitted at the hearing, and control the proceeding. However, the ALJ presiding over oral argument cannot be the same ALJ who presided over the hearing and whose decision was nonadopted in the matter at issue; so the ALJ presiding at oral argument necessarily has little or no knowledge of the sometimes voluminous record in the underlying matter. The required presence of the ALJ adds more expense to this process, and interrupts the hearing schedule of that MQHP ALJ. The respondent must be given an opportunity to address DMQ; however, neither the statute nor the regulations require that the respondent be put under oath when he makes a statement or answers questions. Respondents sometimes stray from the record and/or the topic at hand, and are subject to objections. Well-meaning DMQ panel members often ask questions outside the record, and are subject to more objections.

To the outside observer, the entire DMQ review process seems fraught with (1) apparent conflict of interest; (2) delay in a context where delay may cause irreparable harm; (3) extraordinary expense to the Board, the respondent physician, and the physician population whose license fees support the Board's enforcement program; and (4) uncertainty and potential unfairness that can result

when non-judges with no assured knowledge of the evidence and who function under no defined standard of review are asked to second-guess the findings and conclusions of a professional judge in a profoundly significant legal proceeding. As noted above, the Monitor recommended that DMQ discuss the value of its review of proposed decisions (including the procedure it utilizes to review those matters), which was deferred during 2005.

Since the publication of the *Initial Report*, a superior court issued a decision illuminating the errors that can result from these unusual procedures designed to accommodate adjudicative decisionmaking by non-judges. In its decision, the court found that certain procedural aspects of the DMQ review process denied one physician a fair hearing, vacated DMQ's decision revoking that physician's license, and remanded the matter to the Division for further proceedings. The court took no position on the merits of the matter — that is, the court did not decide whether MBC sustained its burden of proof and/or whether the physician should be disciplined; neither does the Monitor. However, the court's ruling points out significant procedural flaws in the DMQ review process that have occurred because the prosecutorial and judicial functions are not sufficiently separated at the Medical Board, and because non-judges who have no assured familiarity with the evidence are permitted to assume the role of a judge in a momentous legal proceeding; those flaws could be avoided if the ALJ's decision were deemed final.

The Monitor again urges DMQ to meaningfully evaluate the value of its review of proposed ALJ decisions and stipulations, and of the procedure it utilizes to review those matters. The Monitor is aware that many Board members wish to retain their authority to review ALJ recommendations and make disciplinary decisions. However, this is not the universal model. The State Bar Board of Governors does not make disciplinary decisions. The Contractors State License Board does not make disciplinary decisions. If freed from having to spend excessive amounts of time on a function to which they are not necessarily well-suited, and to which others are better suited, MBC members may be able to make greater contributions to public protection by focusing on their important rulemaking, oversight, and general policysetting functions.

4. DMQ's procedures on motions for a stay in order to seek reconsideration appear unfair. In the *Initial Report*, the Monitor noted that either party may seek reconsideration of a DMQ decision, and that Government Code section 11521(a) permits either side to request a short stay of the effective date of the decision to enable counsel to prepare a motion for reconsideration. While MBC's *Discipline Coordination Unit Procedure Manual* is clear that a motion for reconsideration must be decided by a DMQ panel, it allows MBC enforcement staff to rule on a request for stay (and contains criteria to guide staff's decision whether to grant a stay). The Monitor agreed with defense counsel that this procedure — wherein an agent of MBC's executive director (technically the prosecutor in MBC enforcement actions) is able to make decisions affecting the final outcome of a disciplinary matter — appears one-sided and unfair, and recommended that DMQ address this

procedural issue. In response, MBC staff declined to end its role in ruling on motions for stay. Instead, it is in the process of amending its *Discipline Coordination Unit Procedure Manual* to amplify the criteria to guide staff's decision whether to grant the stay.

The Monitor disagrees with this approach. In the Monitor's view, this appears to be another example of the lack of sufficient separation between the prosecutorial and judicial functions at the Medical Board. As illustrated in the recent superior court decision discussed above, agents of the executive director/prosecutor should not even participate in judicial decisionmaking much less engage in it. A recently-adopted DMQ regulation permitting the submission of *amicus curiae* briefs in disciplinary cases requires two panel members to consider and rule on any request to submit an *amicus* brief. If panel members can rule on *amicus* requests within a tight timeframe, there is no reason they cannot similarly rule on requests for stays. The Monitor urges DMQ to properly address this issue and devise a method whereby a panel member is designated to rule on motions for stay.

5. DMQ does not notify both parties if it rejects a stipulated settlement. In the *Initial Report*, the Monitor noted complaints from defense counsel that DMQ does not always notify both counsel if it rejects a stipulation. In October 2005, MBC staff amended section 32 of the *Discipline Coordination Unit Procedure Manual* to require DMQ notice to both sides when it rejects a stipulated settlement.

JUDICIAL REVIEW OF DMQ DECISIONS

A physician whose license has been disciplined may seek judicial review of MBC's decision by filing a petition for writ of mandate in superior court under Code of Civil Procedure (CCP) section 1094.5. The following summarizes the Monitor's *Initial Report* findings and concerns about judicial review of DMQ disciplinary decisions, and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. MBC's venue statute is encouraging "forum-shopping" and inefficient use of judicial resources, and is unnecessarily costing HQE and MBC substantial amounts of money each year. In the *Initial Report*, the Monitor noted that Business and Professions Code section 2019 governs venue for the filing of a petition of writ of mandate challenging a DMQ disciplinary decision. Under section 2019 (which is unique to MBC), a respondent unhappy with a DMQ disciplinary decision may file a petition for writ of mandate in San Diego, Los Angeles, Sacramento, or San Francisco — regardless of where the administrative hearing was held and regardless of where the HQE DAG who prosecuted the case works. This statute has led to apparent "forum-shopping" on the part of defense counsel in search of a sympathetic judge, and requires HQE to fly its DAGs all over the state for writ hearings. Additionally, this practice disrupts the efficient operation of the Attorney General's Office; unfairly overburdens one court funded by the taxpayers of a single

county, while other courts are relatively unused by MBC petitioners; and undermines the integrity of the process. The Monitor recommended that section 2019 be amended to require legal proceedings challenging DMQ decisions to be instituted in the large city closest to where the administrative proceeding was held. Until August 30, SB 231 contained an amendment to section 2019 that would have implemented the Monitor's recommendation. However, the amendment was opposed by CMA and various defense attorneys who represent physicians before MBC; they raised questions regarding the Monitor's "forum-shopping" conclusion. Because this matter warrants further discussion, the amendment was eventually dropped from the bill.

2. MBC is inappropriately subsidizing the cost of the preparation of administrative hearing transcripts for writ proceedings. When a licensee files a CCP section 1094.5 petition for writ of mandate challenging a DMQ disciplinary decision, that petitioner must request the record of the administrative proceeding from the Office of Administrating Hearings. Under section 1094.5, "[e]xcept when otherwise prescribed by statute, the cost of preparing the transcript shall be borne by petitioner." However, due to the interaction of CCP section 1094.5 and Government Code section 69950, the petitioner generally pays only about one-half of the actual cost of the preparation of the transcript, and MBC is billed for the rest. MBC's underwriting or cross-subsidization of the cost of the preparation of the record in writ of mandate proceedings — to the tune of thousands of dollars per transcript and many more thousands of dollars each year — is unnecessary and particularly inappropriate in light of its current financial plight. The Monitor recommended the amendment of section 11523 to require the petitioner to pay the entire cost of the transcript up front.

Section 23 of SB 231 amends Government Code section 11523 to require a petitioner to pay the full cost of hearing transcript preparation to OAH. The amendment preserves the petitioner's right to full reimbursement of this cost if the petitioner prevails in the writ proceeding, and does not affect the right of *in forma pauperis* (indigent) petitioners to a free copy of the transcript under Code of Civil Procedure section 1094.5 and Government Code section 68511.3.

PUBLIC DISCLOSURE

In addition to removing incompetent, negligent, dishonest, and impaired physicians from the marketplace through its enforcement program, another way in which MBC implements its "paramount" public protection priority is by disclosing licensee information to the public, to enable consumers to make informed choices when selecting a health care practitioner. MBC's disclosure of information about physicians is accomplished primarily through its Web site, which is statutorily required and closely governed by several state laws. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's public disclosure policy and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. The fragmented tangle of overlapping statutes — including drafting errors and inconsistencies — frustrates the purpose of MBC's Web site, unnecessarily exposes MBC to litigation, and results in the disclosure of different information depending on the mode of inquiry. In the *Initial Report*, the Monitor found that the purpose of MBC's Web site — to provide the public with easy access to public information about California physicians — has been frustrated by the language of the statutes. As a result of the interaction of many statutory provisions, there are essentially four categories of "information" on physicians and three ways to obtain some (but not all) of it — and one receives different information depending on how and who one asks. In the *Initial Report,* the Monitor outlined several specific inconsistencies and apparent drafting errors in the statutes, and suggested that sections 2027 and 803.1 be consolidated and harmonized to achieve the laudable purposes behind MBC's public disclosure statutes.

SB 231 corrects a drafting error in section 2027(a)(2), and now clearly authorizes MBC to post its own prior disciplinary actions. SB 231 also addresses the public disclosure issue more generally by requiring the Little Hoover Commission, an independent and respected watchdog agency, to "study and make recommendations on the role of public disclosure in the public protection mandate of the board. This study shall include, but not be limited to, whether the public is adequately informed about physician misconduct by the current laws and regulations providing for disclosure." The study must be completed by July 1, 2008.

2. SB 1950's civil settlement disclosure provision has had minimal effect. Prompted by a number of high-profile California cases and precedent in ten other states, section 803.1(b)(2)(A) — added by SB 1950 (Figueroa) in 2002 — authorized MBC to disclose multiple civil malpractice settlements over $30,000 for the first time. However, the statute has had limited effect: Since the bill's effective date of January 1, 2003 to August 10, 2005, the settlements of only eleven physicians have been disclosed on MBC's Web site. In the *Initial Report*, the Monitor recommended that MBC be required to disclose on its Web site all medical malpractice settlements over $30,000 with the disclaimer currently required in section 803.1(c). Rather than reviving this controversial issue so soon after SB 1950 was enacted, Senator Figueroa opted to delegate it to the neutral Little Hoover Commission (see above).

3. MBC is not authorized to disclose misdemeanor criminal convictions that are substantially related to the qualifications, functions, and duties of a physician. In the *Initial Report*, the Monitor noted that, while MBC discloses felony criminal convictions against physicians for an indefinite period, it discloses no misdemeanor criminal convictions no matter their number or seriousness — including misdemeanor convictions that were originally charged as straight felonies and/or "wobblers" but were pled down to misdemeanors. The Monitor echoed the Joint Legislative Sunset Review Committee, the Medical Board, and the Federation of State Medical Boards in calling for the required disclosure of misdemeanor criminal convictions that are substantially related to the qualifications, duties, and functions of a physician.

Section 11 of SB 231 requires MBC to post on its Web site all substantially related misdemeanor criminal convictions against physicians for ten years from the date of the conviction. This new disclosure requirement is not effective until MBC presents to the Legislature, and the Legislature enacts, a list of misdemeanor convictions that are "substantially related." Thus, additional legislation is required, but MBC will soon be permitted to disclose additional criminal convictions that are relevant to consumers when choosing health care providers.

4. MBC is not disclosing all significant terms and conditions of probation on its Web site. Although state law requires MBC to post information about "probations" and "limitations" on its Web site, the *Initial Report* found that MBC does not consistently do so — due in part to limitations imposed by its CAS computer system. In response to the Monitor's recommendation that MBC disclose all significant terms and conditions of public probation orders on its Web site, MBC added a new "enforcement public document search" feature to its Web site as of November 2004. Since then, the Board has posted almost 500 enforcement-related documents — including accusations, disciplinary decisions (including stipulations), public letters of reprimand, and citations — from September 2004 forward. These documents are now available in their entirety on MBC's Web site. As additional resources and staffing become available, MBC will attempt to backload all public enforcement-related documents on its Web site; in the meantime, they are available upon request.

PUBLIC EDUCATION AND OUTREACH

Under the general direction of its Public Education Committee, MBC engages in outreach and public education to various stakeholders, including patients, licensees, mandated reporters, prospective expert reviewers, and the media. MBC's enforcement program is responsible for communicating with complainants and subject physicians during complaint processing and investigations. The following summarizes the Monitor's *Initial Report* findings and concerns about MBC's public education efforts and documents the responses to those findings implemented by MBC, HQE, and the Legislature during 2005.

1. Physicians are not required to provide patients with information about the existence of the Board and its disciplinary jurisdiction. In the *Initial Report*, the Monitor noted that many other regulatory agencies — including health care-related agencies — require their licensees to provide customers or clients with information about their licensing board, its regulatory authority, and its contact information. The Medical Board has never imposed a similar requirement on physicians. The Monitor suggested that MBC sponsor legislation requiring physicians to inform patients about the Medical Board's existence, disciplinary jurisdiction, address, and toll-free complaint number. Neither MBC nor the Legislature took action on this recommendation during 2005. Although this is understandable due to the press of other higher-priority issues (including the

needed fee increase and the fundamental structural change to a vertical prosecution model), this issue should find its way onto the agendas of MBC and its Public Education Committee during 2006. Many California agencies manage their caseloads while still meeting their obligation to help the public seek redress of legitimate grievances. The Monitor believes that, as a matter of sound public policy, the Medical Board should likewise make better efforts to meet its obligation to assist victims of medical wrongdoing in understanding how to be involved with its enforcement program.

2. The Board does not communicate consistently with physicians during the complaint review and investigative process. In the *Initial Report*, the Monitor noted defense counsel complaints that MBC does not always contact subject physicians when complaints against them are closed, and found that its various policy and procedure manuals were inconsistent on this point. In response, MBC revised its *CCU Procedure Manual* and its *Enforcement Operations Manual* to require CCU and its district offices to notify a subject physician who has been contacted by CCU or field staff during complaint processing of the closure of that complaint.

3. MBC should communicate with local county medical societies about their obligations under Civil Code section 43.96. This provision requires medical societies, hospitals, and local government agencies that receive a written complaint against a physician to affirmatively notify the complainant that they have no jurisdiction over the physician's license, and that only MBC may discipline a physician's license. Further, the local entity must "provide to the complainant the address and toll-free telephone number" of the Board. The Monitor suggested that MBC periodically communicate with local county medical societies and remind them of their obligations under section 43.96. During March 2005, MBC's public information officer (PIO) checked the Web sites and/or otherwise contacted all 58 local county medical societies. According to MBC, all but two societies are in compliance with section 43.96. The PIO sent letters to those two societies setting forth the requirements of section 43.96.

MBC'S DIVERSION PROGRAM

The purpose of MBC's Diversion Program is to monitor substance-abusing physicians while they attempt to recover from the disease of addiction. Participants in the Diversion Program include physicians who voluntarily seek help ("self-referrals"), physicians who are referred by the Board's enforcement program during investigation of a complaint ("Board-referred"), and physicians who are ordered to participate by DMQ as a term of probation in a formal disciplinary order ("Board-ordered"). Overseen by a standing Diversion Committee composed of Board members, the Diversion Program is run by MBC employees and is advised by regional Diversion Evaluation Committees (DECs) and by the Liaison Committee to the Diversion Program. In the *Initial Report*, the Monitor — as did the Auditor General in a series of audits over twenty years ago — identified and documented numerous significant deficiencies in the functioning of the Diversion Program. The

following summarizes the Monitor's *Initial Report* findings and concerns about the Diversion Program and documents the responses to those findings implemented by MBC and the Legislature during 2005.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are: (1) random urine screening requirements; (2) case manager attendance at required group therapy meetings; (3) required worksite monitoring; and (4) regular reporting to the Program by psychotherapists who are treating participants. In the *Initial Report*, the Monitor found — as did the Auditor General during the 1980s — that all of these monitoring mechanisms were failing the Program and the public, and that the Program lacked internal quality controls that would otherwise enable staff to detect these failures. Following is a brief summary of the Monitor's *Initial Report* findings about each of the Diversion Program's monitoring mechanisms.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means of monitoring participants' sobriety and detecting relapses. More than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major objective measure of participant compliance with the terms of the contract and with the Program's requirements. Although two levels of Program staff — specifically, the Program's regional case managers (CMs) and the Sacramento-based Collection System Manager (CSM), who establishes a random schedule for testing and is charged with overseeing the overall integrity of the system — were in a position to monitor participant compliance with the Program's urine collection requirements, neither were overseeing the system. Local urine collectors were essentially unsupervised and were free to adjust the random schedule to suit their convenience. They often unilaterally shifted collections to dates that could be anticipated by the participants, or skipped scheduled tests altogether and failed to make them up. These failures went undetected by Program staff. The Monitor found that many Diversion Program participants were tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there was a problem. In 60% of the case files reviewed by the Monitor, testing did not occur on the random dates generated by the CSM; when it occurred, it

occurred with frequency on dates that could be anticipated by the participant. In many cases, test results (including positive test results that indicate relapse) were not promptly communicated from the lab to the Program. When test results were received, they were sometimes appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there was a problem. The Monitor found numerous errors, gaps, and inconsistencies in the Program's recordkeeping on these physicians — recordkeeping that must be available, correct, and reliable in the event of a relapse.

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The *Diversion Program Manual* requires CMs to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants. CMs are required to report their group meeting attendance in monthly reports to the program administrator. However, the Monitor — like the Auditor General in the 1980s — found that few case managers filed monthly reports as required, so there was no documentation as to whether they had attended group meetings as required by Program policy.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired physicians. However, since its inception, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor." No statute, regulation, or procedure manual contains a definition of or standards for a "worksite monitor," or even requires the monitor to be a physician. The Monitor also found that people functioning as worksite monitors were not consistently filing quarterly reports as required by the Program. Yet DECs were recommending that participants be permitted to increase their work hours or resume full-time practice notwithstanding the absence of worksite monitor reports.

(4) Treating psychotherapist reporting is deficient. The Diversion Program also assures the public that impaired physicians are monitored by treating psychotherapists who are required to file quarterly written reports with the Program. However, this monitoring requirement was not being satisfied. Neither the case managers, the program administrator, nor the DECs (which annually review all Program participants) were ensuring that quarterly psychotherapist reports were filed.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them. In the *Initial Report*, the Monitor found significant understaffing of the Diversion Program at all levels: program management, case management, and analytical/clerical support staff. The Monitor recommended that — if the Medical Board chooses to continue administering the Diversion Program — DMQ must spearhead a comprehensive overhaul of the Program to correct longstanding deficiencies that limit the Program's effectiveness. This overhaul must include an influx of additional staff if the Program is to adequately

monitor its participants. However, the Monitor emphasized that the mere addition of staff alone will not solve the Diversion Program's problems. In addition, the Program must install and staff sufficient and significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. Finally, any restructuring of the Diversion Program must include the resolution of significant and longstanding policy issues by the Diversion Committee and DMQ.

To address fundamental flaws in the Program's monitoring mechanisms, MBC Executive Director Dave Thornton — who personally stepped in and served as Acting Diversion Program Administrator from August 2004 through February 2005 — announced in January 2005 his intent to "deconstruct and reconstruct" the Diversion Program, and has taken several initial steps toward that goal. The following improvements have occurred since the release of the *Initial Report*:

■ ***Diversion Program staffing***. Effective February 17, 2005, MBC hired a new Diversion Program Administrator who has significant experience in both enforcement and in impairment programs. On February 8, 2005, MBC added a new management position to the Diversion Program — a supervisor for the case managers. Under the direction of the new program administrator and CM supervisor, the case managers have been moved out of their former home offices and now work from Medical Board district offices. Significantly, on March 1, 2005, the Program formally expanded its existing Collection System Manager position to a full-time position devoted almost entirely to overseeing the operations and integrity of the Program's urine collection system; additionally, another Program analyst has been cross-trained to handle CSM duties when the CSM is on vacation or otherwise out of the office. Finally, MBC has submitted a BCP for additional Diversion Program case managers and the conversion of a seasonal clerical position to a permanent position. The additional CM positions are of particular importance; if approved, average CM caseloads will decrease from over 50 cases to approximately 40 cases each — and should enable CMs to adequately monitor participants and greatly improve the public protection afforded by the Diversion Program. Funding for these positions was included in the Board's calculation of the fee increase in SB 231 (Figueroa) — now passed by the Legislature and signed by the Governor. The Monitor urges all applicable control agencies to approve the creation of these new positions for the Diversion Program.

■ ***Improvements to the Program's urine testing system***. As noted above, the Medical Board has finally devoted a full-time analyst position to the Diversion Program's critical CSM function. The new CSM is in the process of rebuilding the Program's urine collection system from the ground up, and has instituted policies and procedures to ensure that: (1) all active participants are included in the master collection schedule maintained by the CSM; (2) each participant is scheduled for the required number of tests, per the Diversion Program's "frequency of testing" policy; (3) collections are actually completed on the random dates assigned by the CSM; (4) the same number of collections

is completed as is scheduled for each participant; (5) collected specimens are received at and processed by the laboratory; and (6) test results are correctly downloaded and appended to each participant's record in the DTS.

In late 2004, MBC management commissioned the Board's Information Systems Branch (ISB) to create a new DTS to electronically track data (including all results of urine tests) on all Diversion Program participants. ISB created a new system that was up and running as of July 1, 2005; the DTS is now a Web-based real-time system that is accessible to Program case managers at MBC district offices.

■ ***Case manager attendance at group meetings***. The new case manager supervisor now requires and reviews monthly reports filed by case managers that document their compliance with the Program's policy of CM attendance at each group meeting in their region at least once monthly. Most CMs are able to comply with that requirement now.

■ ***Worksite monitoring standards and reporting***. Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly worksite monitor reports. Program staff is working with ISB to develop a program whereby a list of participants who are not in compliance with the worksite monitor requirement is generated. Although worksite monitor reporting has improved, the Diversion Committee has yet to flesh out required qualifications for worksite monitors and the parameters of worksite monitoring.

■ ***Treating psychotherapist reporting***. Under the supervision of the new case manager supervisor, CMs are also beginning to address issues related to the timely filing of quarterly treating psychotherapist reports.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held. In the *Initial Report*, the Monitor found that the Diversion Program is plagued by an almost complete lack of enforceable rules, standards, or expectations to which participants or staff are consistently held. The Diversion Program's statutes and regulations are skeletal at best. None of the monitoring mechanism described above are even mentioned in, much less governed by, statute or regulation. All of the monitoring mechanisms and other Program "rules" and "policies" are contained in an unenforceable "procedure manual" that has not been updated since 1998 and is effectively obsolete. Despite statutory requirements to the contrary, the Program has no meaningful criteria for admission to the Program or termination from the Program. It has no clear standards regarding consequences for or response to relapse. In the *Initial Report*, the Monitor recommended that DMQ adopt meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse. The Monitor also suggested that DMQ establish enforceable standards and consistent expectations

of Diversion Program participants and staff through legislation or the rulemaking process, and oversee a complete revision of the *Diversion Program Manual*. Program staff has commenced an overhaul of the *Diversion Program Manual* — that project is under way. During 2006, the Diversion Committee and DMQ must address the fundamental policy issues identified by the Monitor.

SB 231 did not amend substantive law governing the Diversion Program. However, the bill sunsets the whole program effective July 1, 2008, thus requiring the Legislature to pass and the Governor to sign extension legislation in 2007. For inclusion in that extension legislation, the Diversion Committee and DMQ should submit any substantive policies they have developed — for example, meaningful criteria for termination from the Program; and/or a Penal Code section 1000-type mechanism applicable to Board-ordered and Board-referred participants, which may excise repeat offenders from the Program and result in the revocation of their license without further procedure.

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program. State law requires DMQ to administer the Diversion Program and oversee its functioning. However, both the Auditor General in the 1980s and the Monitor in 2004 found that the Division has failed to adequately supervise and oversee the Diversion Program. One reason for DMQ's failure to adequately oversee the Diversion Program lies in MBC's 1982 creation of the "Liaison Committee to the Diversion Program" (LCD) — a committee which has no statutory existence or authority but was formed and funded by the California Medical Association, the California Society of Addiction Medicine, and (recently) the California Psychiatric Association. Although the LCD was intended to be an advisory body that could offer clinical expertise on addiction issues to DMQ and MBC staff who administer the Diversion Program, over the years it has been delegated responsibility for or has inserted itself into operational, legal, and other issues that do not require clinical expertise. The Monitor recommended that DMQ abolish the Liaison Committee as it currently exists; determine whether there is a need for external clinical expertise; and — if so — convert the Liaison Committee into a workable advisory panel that both serves the needs of DMQ (as determined by DMQ) and makes the very best use of the skills, expertise, and time of Liaison Committee members.

In response, MBC President Ronald Wender, M.D., has appointed a new Diversion Committee headed by DMQ member Martin Greenberg, Ph.D. Dr. Greenberg and the Committee are actively reconsidering the purpose and role of the Liaison Committee, and ways in which volunteer addiction professionals can best provide input to the Program on issues that require clinical expertise.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC

management. For many years, the Medical Board — both the Board and its staff — permitted the Diversion Program to effectively function in a vacuum. In the Monitor's view, this separation resulted in the breakdowns in overall Diversion Program functioning and in the key monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which were not communicated to MBC management so they might be addressed. The Monitor recommended that MBC more effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management — especially concerning Board-ordered and Board-referred participants who are participating in Diversion in lieu of being disciplined.

MBC has responded to this recommendation positively by hiring a new program administrator who has extensive experience in both enforcement and impairment programs. Both the new program administrator and the new case manager supervisor have been actively interacting with MBC's enforcement program and its probation monitors with respect to Board-ordered and Board-referred participants. As described above, the program administrator has moved the Diversion Program's case managers from their home offices into Medical Board district offices. The CMs now function from MBC offices, where they can access the DTS and interact with MBC investigators. Finally, the Diversion Program is actively working to revamp the obsolete *Diversion Program Manual* — a key management function that was ignored for many years.

5. The Program's claim of a "74% success rate" is misleading. In the *Initial Report*, the Monitor noted that the Diversion Program periodically calculates and advertises a "success rate" which — in the Monitor's view — is misleading. The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. At the very least, such a "success rate" claim should not be made without fully explaining its meaning.

The current management and staff of the Diversion Program have ceased making a "success rate" claim. Although no concrete plans have been developed, staff is discussing the possibility of arranging for an external long-term study of both "successfully terminated" and "unsuccessfully terminated" Diversion Program participants in an attempt to determine whether the Program is effective in assisting physicians to recover from addiction. Such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion program structure and operations.

OTHER AREAS OF MONITOR INQUIRY

During the first year of the MBC Enforcement Monitor project, the Monitor was unable to examine several components of MBC's enforcement program that deserve mention.

Citation and Fine Program. Business and Professions Code section 125.9 authorizes MBC to implement, by regulation, a system for the issuance of citations, fines, and orders of abatement for minor or technical violations of the Medical Practice Act or the Board's regulations. In 1994, MBC implemented its citation and fine authority by adopting section 1364.10 *et seq*., Title 16 of the California Code of Regulations. Section 1364.10 permits various board officials to determine when and against whom a citation should be issued, and to issue citations including orders of abatement and fines. Section 1364.11 identifies statutory and regulatory provisions whose violation may justify the issuance of a citation, fine, and/or order of abatement. Section 1364.14 sets forth the procedure for challenging a citation. A cited licensee may request, within ten days after service of the citation, an informal conference with the board official who issued the citation. At the conclusion of the informal conference, the board official may affirm, modify, or dismiss the citation, including any fine levied or order of abatement issued. Thus, the Board's implementation of section 125.9 affords the licensee four levels of procedural due process protection — informal conference, ALJ hearing, DMQ review of ALJ decision, and court review of DMQ's decision — both as to sanction generally and as to the degree of sanction.

In 2004, MBC's handling of citation and fine cases changed significantly — largely as a result of the assignment of a deputy attorney general and a supervising investigator to the Central Complaint Unit; these individuals examined MBC's citation and fine program and prompted several important policy changes that have since been codified in MBC's various procedure manuals. Whether a citation case arises in CCU or in a district office during investigation, MBC's procedure manuals now clarify that a citation will not be issued unless staff has first contacted the subject physician for information, an explanation, and an attempted resolution. Further, citation cases are now subject to review by a supervising investigator and an HQE attorney to determine whether the file includes sufficient evidence of the violation (including documentation of MBC's written contact with the physician and the physician's response, if any).

MBC's recent citation and fine activity indicates a significant decline in the number of citations and fines issued in recent years. MBC insists that it is utilizing the citation and fine remedy judiciously, and mostly in an attempt to educate physicians about their legal responsibilities and encourage compliance with the law. The numbers appear consistent with this claim. The vast majority of citations issued over past three years are citations (with no fines) for failure to notify the Board of a change of address. Many (if not most) citations are withdrawn when compliance is achieved. During 2004–05, CCU issued 59 advisory and educational letters (40 of which were in

quality of care cases) to physicians in lieu of citations and fines — which accounts (in part) for the dramatic decrease in the number of citations issued in 2004–05.

Citations are not considered "disciplinary actions" because they have not been issued by the Division of Medical Quality. However, citations are public information, and are required to be posted on MBC's Web site. In May 2004, CMA questioned the fairness of MBC's posting of the citations on its Web site upon "issuance," before the physician has had an opportunity to request and participate in the informal conference and the "full due process hearing" before the ALJ. The Monitor is informed that MBC representatives met with CMA in March 2005 and offered to institute a procedure whereby MBC will formally notify all physicians ten days in advance of "issuance" and posting that they are about to be cited — in a last attempt to elicit information and cooperation from the physician; according to MBC, CMA has not responded to that offer. The Monitor finds that offer reasonable and is not prepared to recommend other changes in MBC's practice regarding the posting of citations upon their "issuance.

MBC's Probation Unit. Business and Professions Code sections 2227(a)(3) and 2228 authorize DMQ to place the license of a physician on probation subject to specified terms and conditions. In its 2003 disciplinary guidelines, DMQ has identified approximately 35 standard and optional terms and conditions of probation that it may include in a disciplinary order depending on the circumstances of the case. Through probation, DMQ may restrict a license or condition continued practice on fulfillment of a condition; require a physician to take and pass coursework or examinations; and/or require participation in the Physician Assessment and Clinical Education (PACE) program (see below).

Since 1992, MBC has maintained a centralized Probation Unit whose purpose is to protect the public by ensuring that any physician whose license has been placed on probation complies with the terms and conditions imposed in the probationary order. The Unit's investigators monitor an assigned caseload of probationers to ensure that imposed probationary terms and conditions are met; additionally, they investigate new complaints filed against one of their assigned probationers. When a physician's license is put on probation, the assigned probation investigator conducts an intake interview with the physician to secure his signature on various acknowledgment forms and to explain each term and condition of probation to ensure that the physician understands DMQ's expectations. Thereafter, the probation investigator is expected to meet with the probationer at least quarterly; these visits may be scheduled or unannounced. Probation investigators may also meet with any required practice monitor of the probationer, and must generally ensure that the probationer is fulfilling all required terms and conditions of the probationary order.

Recent Probation Unit data indicate that, at any given time during the past four fiscal years, the Probation Unit has monitored approximately 526 probationers. Probation investigators carry an

average caseload of 40 probationers, plus an additional five investigations of new complaints filed against existing probationers; these high caseloads sometimes preclude quarterly in-person meetings between probationer and probation investigator. Collectively, the Probation Unit refers an average of 26 probation violations to HQE, and HQE files an average of 23 petitions to revoke probation every year. According to MBC, HQE DAGs have traditionally been hesitant to file petitions to revoke probation for relatively minor noncompliance with probationary terms; however, MBC has had no other remedy to address that noncompliance. To fill that loophole, MBC is in the process of amending its citation and fine regulations to authorize it to utilize that sanction to address probation violations that do not warrant a petition to revoke probation.

Physician Assessment and Clinical Education Program (PACE). When inserted into a formal disciplinary order, optional condition #19 of DMQ's disciplinary guidelines requires a respondent physician to "enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education (PACE) Program at the University of California San Diego School of Medicine." Founded in 1996 by UCSD Professor William A. Norcross, M.D., PACE offers a relatively unique service — it provides clinical competency assessment for physicians and delivers remedial education for detected deficiencies in the core clinical competency areas identified by the American Council on Graduate Medical Education. Although the PACE staff is small, it can call upon the full resources of the UCSD School of Medicine to assist in the assessment, evaluation, and remedial education of program participants.

Currently, the basic PACE program consists of Phase I (a comprehensive assessment of the physician participant and his/her clinical skills) and Phase II (a five-day clinical education program onsite at the UCSD Medical Center). While PACE participants do not have direct responsibility for patient care, they are integrated into the full spectrum of specialty-specific educational opportunities offered at a busy teaching hospital, including outpatient clinics, inpatient ward rounds, grand rounds and other conferences, and observation of procedures. To the greatest extent possible, PACE customizes Phase II to the results of the Phase I assessment, the perceived deficiency which has resulted in the physician's referral to PACE, and the instructions of DMQ. At the conclusion of Phase II, a PACE faculty member prepares a report on the participant's performance, which is reviewed by a multidisciplinary group. Thereafter, PACE submits a detailed report to DMQ which indicates whether the physician has successfully completed the program, as required by the DMQ probation order. Most physicians who have enrolled in PACE have successfully passed the program.

Over the past nine years, PACE has modified its basic assessment and clinical education program significantly, and has added new programs that can occur subsequent to completion of Phases I and II. PACE has also developed and offers numerous courses that are often required by DMQ as a condition of probation. Finally, PACE is working with MBC and HQE on the creation of a program to assess and remediate surgical skills.

MBC, its licensees, and California patients are fortunate that MBC has ready access to the professionals at PACE and the assessment and education programs that PACE has developed in its nine-year existence. Although optional condition #19 of MBC's disciplinary guidelines allows a physician to complete PACE or an "equivalent" clinical assessment and education program, not all such programs are created equal. DMQ should ensure that any alternative program claiming to be "equivalent" administers the same assessment techniques, demands the same remedial education, and is as responsive to DMQ as PACE has been.

CONCLUSION AND RECOMMENDATIONS FOR THE FUTURE

During the pendency of the Enforcement Monitor project, major reform of MBC's enforcement program has successfully begun and significant improvements in the efficiency of the Board's disciplinary system are being achieved as the result of the collaborative efforts of a broad coalition of stakeholders. The long-term prospects for further improvement are excellent.

The Medical Board and the Health Quality Enforcement Section of the Attorney General's Office have embraced most of the Monitor's 65 recommendations for reform, and the initial results are praiseworthy. Through the combined efforts of the Medical Board, its staff, HQE management and staff, the Legislature, and many others, the following improvements have been realized:

- MBC will soon benefit from a 30% increase in operating revenues to dramatically boost enforcement program resources.

- The vertical prosecution system, the modern paradigm for complex regulatory casework of this kind, will be employed by MBC and HQE staff working together in case teams, starting January 1, 2006.

- MBC's processes for gathering medical records and obtaining physician interviews have been streamlined and strengthened, and key indicators of delay are already on the decline.

- Timely exchange of expert opinions in MBC administrative actions will soon be the rule, increasing informed case evaluation and earlier case disposition.

- Operations manuals and training efforts have been extensively updated and enhanced.

- The Central Complaint Unit's structure and process have been improved, and relevant complaint processing times have dropped by 16% already.

■ The Board's Diversion Program has undergone a dramatic change of direction with the intent of "reconstructing" the program to better protect the public, and significant operational improvements have been implemented despite continuing resource shortages.

■ The long-overdue study of the peer review process will soon commence, and hopefully lead to amendments to section 805 that improve MBC's ability to detect physician incompetence and misconduct.

■ MBC's program of public disclosure of physician information to improve informed consumer choice has been upgraded and will now be reevaluated by a respected oversight agency.

The matrix included in Chapter XVII, which summarizes the status of the Monitor's 65 recommendations, demonstrates that MBC, HQE, and the Legislature have implemented (in whole or in part) or will soon implement 50 of the Monitor's 65 recommendations, and others are under active consideration. The Monitor applauds the commitment to improvement and the gratifying efforts to bring about that change by the Medical Board, HQE, the Legislature, and many other stakeholders. However, a great deal of work remains before the Medical Board's enforcement program fulfills its potential as a model of public protection. The *Final Report* contains a number of recommendations for future action, including the following:

■ Full and immediate access to the new enforcement program resources from SB 231.

■ Full and effective implementation of the vertical prosecution system, ultimately resulting in the transfer of MBC's investigators to HQE after 2007, including the prompt development of operating protocols and implementation of the case team process; rapid retraining of MBC and HQE staff in the new procedures; a jointly-developed operations manual for MBC and HQE staff; and expanded use of ProLaw by HQE and the earliest feasible shift-over to the ProLaw system by MBC.

■ Continued enforcement of the vigorous new "zero tolerance" policies on medical records procurement and investigative interviews.

■ Greater use of expedited disciplinary tools, including ISO/TRO powers, Penal Code section 23 authority, and subpoena enforcement.

■ Full staffing of HQE, as required by Government Code section 12529(c), and increased HQE assistance for CCU, as required by Government Code section 12529.5(b).

■ Improved insurer/employer reporting of malpractice payouts.

- Increased hourly rates for records review and report preparation by expert reviewers.

- Evaluation of the costs and benefits of DMQ review of proposed case dispositions.

- New DMQ procedure on requests for stay.

- Development of the required list of disclosable "substantially related" misdemeanor criminal convictions.

- Required notice to consumers regarding the Board's existence and disciplinary jurisdiction.

- Full resolution of longstanding policy issues affecting the Diversion Program, including the development of standards for termination from the Program and consequences for relapse; an examination of options for Program funding to ensure adequate monitoring; the development of standards for worksite monitors; and revamped governance of the program.

The many process improvements now under way, and the important reforms coming soon as the result of SB 231 (Figueroa), point to a brighter future for MBC and its disciplinary process. MBC's enforcement program has demonstrated strong new momentum and clear improvement, but further progress is needed for this agency to fully meet its vital public safety obligations.

The Monitor calls upon every stakeholder in the healthcare system — MBC, HQE, OAH, the Department of Consumer Affairs, the Legislature, organized medicine and the healthcare industry, physicians, and patients — to embrace the cause of a better Medical Board enforcement program. An ongoing collaborative effort to continue MBC's recent progress will result in greater protection for every Californian who relies on the healthcare system.